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REPORT
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FAMILY HEALTH SERVICES AMENDMENTS ACT OF 1988

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Mr. KENNEDY, from the Committee on Labor and Human Resources, submitted the following

REPORT

[To accompany S. 2385]

The Committee on Labor and Human Resources, having considered an original bill to amend title III of the Public Health Service Act to revise and extend the programs of assistance for primary health care, the program of health services for the homeless, and the program for the prevention and control of sexually transmitted diseases, and for other purposes, reports favorably thereon without amendment and recommends that the bill do pass.

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I. SUMMARY OF THE BILL

As reported by the Committee, the bill revises and extends the authority under title III of the Public Health Service (PHS) Act for the programs of assistance for primary health care, the program of health services for the homeless, and the program for the prevention and control of sexually transmitted diseases (STD).

S543-7

TITLE I—PRIMARY HEALTH CENTERS

The bill amends the authorities under sections 329 and 330 of the PHS Act for support of Migrant Health Centers and Community Health Centers. In addition to extending the authorities of both programs for 3 years, through FY 1991, the bill authorizes the Secretary to set aside a portion of the appropriation for each program each year for the provision of services targeted at reducing the incidence of infant mortality. These targeted funds will be used in part to develop and coordinate referral arrangements between migrant and community health centers and entities for the health management of infants and pregnant children.

Title I of the bill amends sections 329 and 330 to include patient case management services in the list of services that they provide to the populations they serve. In addition, the bill amends the authorities of both sections 329 and 330 to permit the use of grant funds for expansion of existing buildings and construction of new buildings in addition to acquisition and modernization of existing buildings, which is permitted under current authority. The bill also amends the way in which the amount of the grant to a migrant or community health center is determined, and reward efficient management by allowing centers to retain fees, premiums, and third party reimbursements that are greater than the amount projected at the beginning of the year. The bill also authorizes procedures for termination of grants and denial of application for grants under the migrant and community health centers programs.

TITLE II—HEALTH SERVICES FOR THE HOMELESS

Title II of the bill extends through FY 1991 the authority in section 340 of the PHS Act for grants for health services for the homeless authorized in P.L. 100–77, the Stewart B. McKinney Homeless Assistance Act of 1987. The bill authorizes an increase in the required matching funds for grants under this authority and modifies the provision for eligibility for a waiver from the matching fund requirements. The bill also amends the authority to permit grantees to continue to provide health services for 12 months to a homeless individual who has become a resident in permanent housing.

TITLE III—PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED DISEASES

Title III of the bill extends for 3 years the authority in section 318 of the PHS Act for projects and programs for the prevention and control of sexually transmitted diseases. The authority is also amended to include grants for the prevention and control of, and grants for research and other projects, programs, and activities relating to chlamydia.

II. Background and Need for Legislation

COMMUNITY HEALTH CENTERS AND MIGRANT HEALTH CENTERS

The Community Health Centers (CHC) and Migrant Health Centers (MHC) programs are the principal Federal health service delivery program for medically underserved areas of the country and medically underserved populations. The CHC program as author-

ized under section 330 of the PHS Act was established in 1975 by Public Law 94-63. The legislation grew out of earlier initiatives for funding neighborhood health centers and family health centers. Currently, the authority under section 330 authorizes the Secretary of Health and Human Services to award grants for projects to provide the primary health care services to medically underserved populations. The authority defines a medically underserved populations as an urban or rural area or population group designated by the Secretary as having a shortage of personal health services. In designating a medically underserved area, the Secretary takes into consideration the following factors:

(1) Available health resources in relation to the size of the area and its population, including appropriate ratios of primary care physicians in general or family practice, internal medicine, pediatrics, or obstetrics and gynecology to the area's population;

(2) Health indices for the population of the area, such as infant mortality rates;

(3) Economic factors affecting the population's access to health services, such as percentage of the population with incomes below the poverty level; and

(4) Demographic factors affecting the population's need and demand for health services, such as percentage of population age 65 and over.

The Migrant Health Centers program supports primary health services as well as certain supplemental and environmental health services for migratory and seasonal agricultural workers and their families. A migratory agricultural worker is one whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes a temporary abode for the purposes of such employment. A seasonal agricultural worker is a person whose principal employment is in agriculture on a seasonal basis but who is not a migratory worker.

The MHC program was established by the Migrant Health Act of 1962, Public Law 87-692, and authorized in its current form in 1975 by Public Law 94-63. Under the MHC authority in section 329 of the PHS Act, State and local agencies are eligible to apply for grants to establish and operate health centers for migratory and seasonal farmworkers and their families living in communities which experience influxes of migrant workers.

In FY 1988, 540 CHCs are provide primary care services to approximately 5.25 million medically underserved persons; 117 MHCs are providing care to approximately 470,000 migrants and seasonal farmworkers and their families. Of those served by CHCs and MHCs, it is estimated that 60 percent are poor, 58 percent lack any form of health insurance, over one-third are children under the age of 14, and over one-third are women of child bearing age.

Both the CHC and MHC programs make a significant contribution in the fight to reduce infant deaths in the United States. While the United States has continued to make strides in reducing infant mortality, there has been a recognized decline in the rate of progress in recent years. The United States now ranks 17th in the world in its infant mortality rate. Over 40,000 of the 3.76 million children who were born in the United States in 1985 died before

their first birthday, a rate of 10.6 deaths per 1,000 live births. The disparity between black and white infant mortality is particularly alarming; black infants are nearly twice as likely as white infants to die in the first year of life. At our current rate of progress, the United States has little chance of meeting the Surgeon General's goal of reducing the infant mortality rate to 9 deaths per 1,000 live births by 1990.

Two thirds of all infant mortality can be attributed to those infants born at low birthweight. Low birthweight infants are 40 times more likely than normal birthweight babies to die in the first month of life, and 20 times more likely in the first year. They are also far more likely to have birth defects and mental and physical handicaps, which often mean lifelong challenges, hardships, and expenses for themselves, their families, and society.

Low birthweight is largely preventable, and at relatively low cost. Early prenatal care can reduce the number of infants born at low birthweight by two-thirds. CHCs and MHCs are ideally situated to provide the kind of prenatal care that can save babies' lives. This Committee last year reported, and the Senate passed a bill, S. 1441, designed to provide added financial support to these centers to help them attack infant mortality in the United States. Although the House passed a similar bill, final action was not taken on either proposal. The Congress, however, did appropriate, through the FY 1988 Continuing Resolution, $20 million for an Infant Mortality Initiative. These funds are being awarded as supplemental demonstration grants to CHCs and MHCs to help them integrate and coordinate appropriate services throughout the pregnancy and first year of life in order to meet effectively the health care needs of mothers and infants.

HEALTH SERVICES FOR THE HOMELESS

The problems of the homeless in America have touched the Nation in recent years. According to an estimate by the Congressional Budget Office, approximately 1 million men, women, and children in this country are homeless at some point during the year. The homeless include families with children, mentally ill persons, and persons suffering from substance abuse. The homeless are vulnerable to illness just as anyone else is, and particularly because of adverse conditions on the street or in emergency shelters. They face barriers in obtaining access to medical care, partly because they are uninsured and lack the ability to pay for services, and partly because the traditional health care delivery system is not designed to accommodate their needs.

In 1987, the Congress enacted legislation to authorize Federal support for a broad variety of services for homeless. The Stewart B. McKinney Homeless Assistance Act of 1987, Public Law 100–77, among other things, authorized a program of project grants to local public and private nonprofit entities to support the delivery of health services to homeless persons. Under this authority, a total of $46 million was appropriated in FY 1987 and awarded at the beginning of FY 1988. These awards went to 109 communities in 43 States and the District of Columbia to provide services to homeless populations located primarily in urban settings. These grant

awards are expected to support the delivery of health services to an estimated 400,000 homeless men, women, and children.

SEXUALLY TRANSMITTED DISEASE PREVENTION AND CONTROL

The growing spectrum of STD presents one of the most complex public health problems confronting our society. Until fairly recently, the scope of such diseases was limited to just a few classical infections, led by gonorrhea and syphilis. At the present time, however, literally dozens of organisms and syndromes are recognized as being sexually transmitted. The list of STD now includes chlamydia infections, genital herpes, human papilloma virus, genital mycoplasma, cytomegalovirus, hepatitis, vaginitis, enteric infections, and ectoparasite diseases. These infections have achieved prominence in recent years as STD for a variety of reasons: new diagnostic approaches have facilitated determining the extent, method of transmission, and clinical consequences of these infections; the incidence of these STD has increased, many at an alarming rate; a high proportion of systemic diseases are being sexually transmitted; and the key impact of STD on maternal and child health is now apparent.

An estimated 14 million cases of STD—including 2 million cases of gonorrhea; 85,000 cases of syphilis; 500,000 cases of genital herpes; 200,000 cases of hepatitis B; 3 million cases of trichomoniasis; 1 million cases of human papilloma virus, and 4 million cases of chlamydia—threaten the health of Americans each year. These cases are particularly critical among adolescents and young adults. Approximately 2.5 million teenagers are infected with an STD annually and 65 percent of all STD cases occur among persons less than 25 years of age.

Women and children bear an inordinate share of the physical and emotional burden of STD. The most serious public health complications caused by STD are pelvic inflammatory disease (PID), infertility, ectopic pregnancy, adverse pregnancy outcome, infant pneumonia, infant death, mental retardation, and neoplasia.

With an estimated 4 million cases a year, chlamydia has become the most common STD in the Nation. It has become alarmingly common and is adding significantly to the increasing incidence of sterility among our young people. Between 7 and 14 percent of all pregnant woman are infected by this disease. There are over 150,000 infants born to infected mothers, and they are at risk for pneumonia and conjunctivitis. In addition, chlamydia accounts for approximately 40 percent of the women with PID, which frequently leads to sterility and unnecessarily deprives far too many families of the opprotunity to have children.

The programs and projects for the prevention and control of STD authorized under section 318 of the PHS Act and administered by CDC support a broad attack against these diseases. Project grants awarded to State and local health departments and appropriate public and nonprofit private entities emphasize the reduction of STD morbidity and mortality. Program components carried out with technical and financial assistance under the project grant authority include screening, controlling outbreaks, maintaining sur-

veillance systems, referral services, prevention messages to persons at risk, clinical skills training, and other related activities.

III. TEXT OF THE BILL AS REPORTED

A bill to amend title III of the Public Health Service Act to revise and extend the programs of assistance for primary health care, the program of health services for the homeless, and the program for the prevention and control of sexually transmitted diseases, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Family Health Services Amendments Act of 1988".

(b) TABLE OF CONTENTS.—The table of contents is as follows:

Sec. 1. Short title: table of contents.
Sec. 2. References to the Public Health Service Act.

TITLE I—PRIMARY HEALTH CENTERS

Sec. 101. Migrant health centers.
Sec. 102. Community health centers.
Sec. 103. Requirement with respect to frontier areas.
Sec. 104. Administration of programs.

TITLE II—HEALTH SERVICES FOR THE HOMELESS

Sec. 201. Increase in required amount of matching funds and modification in eligibility for waiver with respect to matching funds.
Sec. 202. Temporary continued provision of services to certain former homeless individuals.
Sec. 203. Clarification of certain provisions.
Sec. 204. Authorizations of appropriations.

TITLE III—PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED DISEASES

Sec. 301. Projects and programs for the prevention and control of sexually transmitted diseaes.

SEC. 2. REFERENCES TO THE PUBLIC HEALTH SERVICE ACT.

Except as otherwise specifically provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act (42 U.S.C. 201n et seq.).

TITLE I—PRIMARY HEALTH CENTERS

SEC. 101. MIGRANT HEALTH CENTERS.

(a) DEFINITION.—Section 329(a)(1) (42 U.S.C. 254b(a)(1)) is amended—

(1) in subparagraph (F), by striking out "and";

(2) in subparagraph (G), by adding "and" after the comma at the end thereof; and

(3) by adding at the end thereof the following new subparagraph:

"(H) patient case management services (including outreach, counseling, referral, and follow-up),"

(b) HIGH IMPACT AREA DEFINITION.—Section 329(a)(5) (42 U.S.C. 254b(a)(5)) is amended by adding at the end thereof the following

new sentence: "The Secretary may not remove a project or program's 'high impact area' designation unless and until the project or program is afforded reasonable notice and an opportunity to provide data and information in support of continuing such designation.".

(c) SUPPLEMENTAL HEALTH SERVICES DEFINITION.—Section 329(a)(7) (42 U.S.C. 254b(a)(7)) is amended—

(1) in subparagraph (K), by striking out "and";

(2) in subparagraph (L), by striking out the period at the end thereof and inserting in lieu thereof "; and"; and

(3) by adding at the end thereof the following new subparagraph:

"(M) other services appropriate to meet the health needs of the service area population.".

(d) GRANTS FOR EXPANSION AND CONSTRUCTION.—The second sentence of section 329(c)(1)(A) (42 U.S.C. 254b(c)(1)(A)) is amended by striking out "acquisition and modernization of existing buildings" and inserting in lieu thereof "acquisition, expansion, and modernization of existing buildings, and construction of new facilities".

(e) COSTS OF OPERATION.—Section 329(d)(2) (42 U.S.C. 254b(d)(2)) is amended by striking out "acquiring and modernizing existing buildings" and inserting in lieu thereof "acquiring, expanding, and modernizing existing buildings, and construction of new facilities".

(f) AMOUNT OF GRANTS FOR COSTS OF OPERATION.—Section 329(d)(4) (42 U.S.C. 254b(d)(4)) is amended—

(1) by striking out subparagraph (A) and inserting in lieu thereof the following new subparagraph:

"(4)(A) The amount of any grant made in any fiscal year under subparagraph (A) of paragraph (1) to a health center shall be determined by the Secretary, but may not exceed the amount by which the costs of operation of the center in such fiscal year exceed the total of the fees, premiums, and third party reimbursements (as well as State, local, and other operational funding), which the center may reasonably be expected to receive for its operations in such fiscal year. In determining the amount of such a grant for a center, if the application for the grant requests funds for a service described in subparagraph (D) or (E) of subsection (a)(1) (other than to the extent the funds would be used for the improvement of private property) or a supplemental health service described in subsection (a)(7), the Secretary shall include, in an amount determined by the Secretary and to the extent funds are available under appropriation Acts, funds for such service unless the Secretary makes a written finding that such service is not needed and provides the applicant with a copy of such finding."; and

(2) in subparagraph (B)—

(A) by striking out "clauses (i) and (ii) of" in clause (i); and

(B) by striking out "may retain such an amount (equal to not less than one-half of the amount by which such sum exceeded such costs) as the center can demonstrate to the satisfaction of the Secretary will be used to enable the center" in the matter immediately following clause (ii), and inserting in lieu thereof "shall be entitled to retain

the additional amount of fees, premiums, and other third party reimbursements as the center will use".

(g) APPLICATION.—Section 329(f)(3)(F)(i) (42 U.S.C. 254b(f)(3)(F)(i)) is amended by inserting "which is consistent with locally prevailing rates or charges and which is" after "of its services".

(h) AUTHORIZATION OF APPROPRIATIONS.—Section 329(h) (42 U.S.C. 254b(h)) is amended—

(1) by striking out paragraph (1) and inserting in lieu thereof the following new paragraph:

"(h)(1) For the purposes of subsections (c), (d), and (e), there are authorized to be appropriated $52,400,000 for fiscal year 1989, and such sums as are necessary in each of the fiscal years 1990 and 1991. The Secretary may not obligate for grants and contracts under subsection (c)(1) in any fiscal year an amount which exceeds 2 per centum of the funds appropriated under this paragraph for that fiscal year, the Secretary may not obligate for grants under subsection (d)(1)(C) in any fiscal year an amount which exceeds 5 per centum of such funds, and the Secretary may not obligate for contracts under subsection (e) in any fiscal year an amount which exceeds 10 per centum of such funds."; and

(2) by adding at the end thereof the following new paragraphs:

"(3)(A) In any case in which the amounts appropriated under paragraph (1) exceed $47,400,000 for fiscal year 1989, $51,400,000 for fiscal year 1990, or $55,000,000 for fiscal year 1991, the Secretary shall make the total amount of such excess available for grants to migrant health centers for—

"(i) the provision of services for the reduction of the incidence of infant mortality; and

"(ii) the development and coordination of referral arrangements between migrant health centers and entities for the health management of infants and pregnant women.

"(B) In making grants described in subparagraph (A) from amounts made available pursuant to subparagraph, the Secretary shall give priority to migrant health centers providing services in any catchment area in which there is a substantial incidence of infant mortality or in which there is a significant increase in the incidence of infant mortality.

"(4) The Secretary shall prescribe procedures to assure that—

"(A) Grants under subsection (d) of this section to a program or project shall not be terminated in whole or in part unless there is cause and the program or project has first been afforded reasonable notice and opportunity for a hearing on the record.

"(B) No applicant for a grant under subsection (d) of this section from a program or project that received such a grant in the prior years shall be denied in whole or in part unless there is cause and the program or project has first been afforded reasonable notice and opportunity for a hearing on the record before the Administrator of the Health Resources and Services Administration.".

SEC. 102. COMMUNITY HEALTH CENTERS.

(a) DEFINITION.—Section 330(a) (42 U.S.C. 254c(a)) is amended—

(1) in paragraph (4), by striking out "related to health, and" and inserting in lieu thereof "related to health";

(2) in paragraph (5), by striking out the period and inserting in lieu thereof "; and"; and

(3) by adding at the end thereof the following new paragraph:

"(6) patient case management services (including outreach, counseling, referral, and follow-up).".

(b) SUPPLEMENTAL HEALTH SERVICES DEFINITION.—Section 330(b)(2) (42 U.S.C. 254c(b)(2)) is amended—

(1) in subparagraph (L), by striking "and";

(2) in subparagraph (M), by the period and inserting in lieu thereof "; and"; and

(3) by adding at the end thereof the following new subparagraph:

"(N) other services appropriate to meet the health needs of the service area population.".

(c) NOTICE OF PROPOSED REGULATIONS.—Section 330(b) (42 U.S.C. 254c(b)) is amended by adding at the end thereof the following new paragraph

"(7) The Secretary may not change the criteria established under paragraph (4) without affording public notice and an opportunity for comment on any such proposed changes in accordance with section 553 of title 5, United States Code.".

(d) GRANTS FOR EXPANSION AND CONSTRUCTION.—Section 330(c)(1) (42 U.S.C. 254c(c)(1)) is amended in the second sentence by striking out "acquisition and modernization of existing buildings" and inserting in lieu thereof "acquisition, expansion, and modernization of existing buildings, and construction of new facilities".

(e) COSTS OF OPERATION.—Section 330(d)(2) (42 U.S.C. 254c(d)(2)) is amended by striking out "acquiring and modernizing existing buildings" and inserting in lieu thereof "acquiring, expanding, and modernizing existing buildings, and construction of new facilities".

(f) AMOUNT OF GRANTS FOR COSTS OF OPERATION.—Section 330(d)(4) (42 U.S.C. 254c(d)(4)) is amended—

(1) by striking out subparagraph (A) and inserting in lieu thereof the following new subparagraph:

"(4)(A) The amount of any grant made in any fiscal year under paragraph (1) (other than subparagraph (C)) to a community health center shall be determined by the Secretary, but may not exceed the amount by which the costs of operation of the center in such fiscal year exceed the total of the fees, premiums, and third party reimbursements (as well as State, local, and other operational funding), which the center may reasonably be expected to receive for its operations in such fiscal year. In determining the amount of such a grant for a center, if the application for the grant requests funds for a service described in subsection (a)(4) (other than to the extent the funds would be used for the improvement of private property) or a supplemental health service described in subsection (b)(2), the Secretary shall include, in an amount determined by the Secretary and to the extent funds are available under appropriation Acts, funds for such service unless the Secretary makes a written finding that such service is not needed and provides the applicant with a copy of such finding."; and

(2) in subparagraph (B)—

(A) by striking out "clauses (i) and (ii) of" in clause (i); and

(B) by striking out "may retain such an amount (equal to not less than one-half of the amount by which such sum exceeded such costs) as the center can demonstrate to the satisfaction of the Secretary will be used to enable the center" in the matter immediately following clause (ii), and inserting in lieu thereof "shall be entitled to retain the additional amount of fees, premiums, and third party reimbursements as the center will use".

(g) APPLICATION.—Section 330(e)(3)(F)(i) (42 U.S.C. 254c(e)(3)(F)(i)) is amended by inserting "which is consistent with locally prevailing rates or charges and which is" after "of its services".

(h) AUTHORIZATION OF APPROPRIATIONS.—Section 330(g) (42 U.S.C. 254c(g)) is amended—

(1) by striking out paragraph (1) and inserting in lieu thereof the following new paragraph:

"(g)(1) There are authorized to be appropriated for payments pursuant to grants under this section $500,000,000 for fiscal year 1989, and such sums as may be necessary in each of the fiscal years 1990 and 1991."; and

(2) by adding at the end thereof the following new paragraphs:

"(4)(A) In any case in which the amounts appropriated under paragraph (1) exceed $435,000,000 for fiscal year 1989, $465,000,000 for fiscal year 1990, or $495,000,000 for fiscal year 1991, the Secretary shall make the total amount of such excess available for grants to community health centers for—

"(i) the provision of services for the reduction of the incidence of infany mortality; and

"(ii) the development and coordination of referral arrangements between community health centers and entities for the medical management of infants and pregnant women.

"(B) In making grants described in subparagraph (A) from amounts made available pursuant to such subparagraph, the Secretary shall give priority to community health centers providing services to any medically underserved population among which there is a substantial incidence of infant mortality or among which there is a significant increase in the incidence of infant mortality.

"(5) The Secretary shall prescribe procedures to assure that—

"(A) Grants under subsection (d) of this section to a center or project shall not be terminated in whole or in part unless there is cause and the center or project has first been afforded reasonable notice and opportunity for a hearing on the record; and

"(B) No application for a grant under subsection (d) of this section from a center or project that received such a grant in the prior year shall be denied in whole or in part unless there is cause and the center or project has first been afforded reasonable notice and opportunity for a hearing on the record before the Administrator of the Health Resources and Services Administration.".

SEC. 103. REQUIREMENT WITH RESPECT TO FRONTIER AREAS.

Section 330 (42 U.S.C. 254c) is amended by adding at the end thereof the following new subsection:

"(j) In making grants under this section, the Secretary shall give special consideration to the unique needs of frontier areas.".

SEC. 104. ADMINISTRATION OF PROGRAMS.

Subpart I of part D of title III (42 U.S.C. 254B et seq.) is amended by adding at the end thereof the following new section:

"SEC. 330A. ADMINISTRATION OF PROGRAMS.

"The Secretary may delegate the authority to administer the programs authorized under section 329 and section 330 to any office within the Public Health Service, except that the authority to enter into, modify, or issue approvals with respect to grants or contracts, may be delegated only within the central office of the Health Resources and Services Administration.".

TITLE II—HEALTH SERVICES FOR THE HOMELESS

SEC. 201. INCREASE IN REQUIRED AMOUNT OF MATCHING FUNDS AND MODIFICATION IN ELIGIBLE FOR WAIVER WITH RESPECT TO MATCHING FUNDS.

(a) INCREASE IN REQUIRED AMOUNT.—Section 340(e)(1)(A)(ii) (42 U.S.C. 256(e)(1)(A)(ii)) is amended by striking out "Federal funds provided in such grant" and inserting in lieu thereof the following: "Federal funds provided for the first fiscal year of payments under the grant and not less than $1 (in cash or in kind under such subparagraph) for each $3 of Federal funds provided for any subsequent fiscal year of payments under the grant".

(b) EFFECTIVE DATE FOR INCREASE.—The amendments made by subsection (a) shall take effect October 1, 1989.

(c) MODIFICATION IN ELIGIBILITY FOR WAIVER.—Section 340(e)(2) (42 U.S.C. 256(e)(2)) is amended to read as follows:

"(2) The Secretary may waive the requirement established in paragraph (1)(A) if the applicant involved is a nonprofit private entity and the Secretary determines that it is not feasible for the applicant to comply with such requirement.".

SEC. 202. TEMPORARY CONTINUED PROVISION OF SERVICES TO CERTAIN FORMER HOMELESS INDIVIDUALS.

(a) IN GENERAL.—Section 340 (42 U.S.C. 256) is amended—

(1) by redesignating subsections (h) through (q) as subsections (i) through (r), respectively; and

(2) by adding after subsection (g) the following new subsection:

(h) TEMPORARY CONTINUED PROVISION OF SERVICES TO CERTAIN FORMER HOMELESS INDIVIDUALS.—If any grantee under subsection (a) has provided services described in subsection (f) or (g) to a homeless individual, any such grantee may, notwithstanding that the individual is no longer homeless as a result of becoming a resident in permanent housing, expend the grant to continue to provide such services to the individual for not more than 12 months.".

(b) CONFORMING AMENDMENTS.—

(1) Section 340(d)(1) (42 U.S.C. 256(d)(1)) is amended—

(A) in subparagraph (C), by striking out "(h)" and inserting in lieu thereof "(i)";

(B) in subparagraph (D), by striking out "(i)" and inserting in lieu thereof "(j)";

(C) in subparagraph (E), by striking out "(j)" and inserting in lieu thereof "(k)"; and

(D) in subparagraph (F), by striking out "(k)" and inserting in lieu thereof "(l)".

(2) Section 332(a)(3) (42 U.S.C. 254e(a)(3)) is amended by striking out "340(q)(2)" and inserting in lieu thereof "340(r)".

(3) Section 536(l) (42 U.S.C. 290cc-36(l)) is amended by striking out "340(q)(2)" and inserting in lieu thereof "340(r)".

SEC. 203. CLARIFICATION OF CERTAIN PROVISIONS.

(a) PROVISION OF TECHNICAL ASSISTANCE.—Section 340(o)(2) (as redesignated in section 202(a)(1) of this Act) is amended by striking out "(p)(1)," and inserting in lieu thereof "(q)(1) for a fiscal year,".

(b) DEFINITION OF HOMELESS INDIVIDUAL.—Section 340(r)(2) (as redesignated in section 202(a)(1) of this Act) is amended by striking out "living accommodations." and inserting in lieu thereof "living accommodations and an individual who is a resident in transitional housing.".

SEC. 204. AUTHORIZATIONS OF APPROPRIATIONS.

Paragraph (1) of section 340(q) (as redesignated in section 202(a)(1) of this Act) is amended to read as follows:

"(q)(1) There are authorized to be appropriated to carry out this section $61,200,000 for fiscal year 1989, $63,600,000 for fiscal year 1990, and $66,200,000 for fiscal year 1991.".

TITLE III—PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED DISEASES

SEC. 301. PROJECTS AND PROGRAMS FOR THE PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED DISEASES.

Section 318 (42 U.S.C. 247c) is amended—

(1) by striking out paragraph (1) of subsection (e) and inserting in lieu thereof the following new paragraph:

"(1)(A) For grants under subsections (b), (c), and (d), there are authorized to be appropriated $100,000,000 for fiscal year 1988 and such sums as may be necessary for each of the fiscal years 1989 and 1990.

"(B) For grants under subsection (b) for any fiscal year, the Secretary shall obligate not less than 10 percent of the total amount appropriated for such fiscal year under subparagraph (A).

"(C) Grants made under subsection (b), (c), or (d) shall be made under such terms and conditions as the Secretary finds necessary to carry out the purposes of such subsection, and payments under any such grants shall be made in advance by way of reimbursement and in such installments as the Secretary finds necessary."; and

(2) by adding at the end thereof the following new subsection:

"(h) Grants under subsections (b) and (c) shall include grants for the prevention and control of, and grants for research and other projects, programs, and activities relating to, chlamydia.".

IV. Committee Views

TITLE I—PRIMARY HEALTH CENTERS

Community Health Centers are established to provide primary health care to residents of medically underserved areas, and Migrant Health Centers are established to provide primary health care to migrant and seasonal farmworkers. This legislation would reauthorize the Community Health Centers (Section 330, PHS Act) ands the Migrant Health (Section 329, PHS Act) programs for a three-year period, through fiscal year 1991. The Committee reaffirms its strong support for these vital health service delivery systems, and its desire to continue their efforts to serve the medically underserved and farmworkers populations, with special atention to those women who are at greatst risk of inadequate prenatal care and those infants who are at greatest risk of not surviving their first year of life. The Committee bill would direct that, in each first year, certain additional appropriations be targeted for grants to C/MHCs to reduce infant mortality through enhanced perinatal care services and coordination. The bill would also revise the basic statutory provisions in order to promote the stability, continuity, and effectiveness of the Community and Migrant Health Center (C/MHC) programs.

A. GRANTS FOR SERVICES TO REDUCE INFANT MORTALITY

The Committee recognizes that it is well established that appropriate and timely prenatal care and primary care for infants can reduce infant mortality and improve the health of infants. Studies by the United States Congress Office of Technology Assessement (OTA), the Institute of Medicine (IOM) of the National Academy of Sciencies, and other scientific bodies repeatedly have demonstrated that appropriate care during pregnancy, including early, ongoing, comprehensive prenatal care and risk-appropriate delivery services, can significantly reduce the incidence of infant mortality and low birthweight. These studies have also found that adequate maternity care not only pays for itself but actually can reduce high cost expenditures to treat infants whose death or disability might have been prevented. Specifically, the IOM has found that each dollar spent to furnish high quality maternity care can save over 3 dollars, while the OTA, in a recent report, has concluded that every low birthweight birth which is averted saves Medicaid between $14,000 and $30,000. Over the past two decades, infant mortality reates for both blacks and whites here in the United States have fallen. In 1970, the infant motality rate for whites was 17.8 per 1,000 live births, and for blacks 32.6 per 1,000 live births. In 1984 the rate for whites was 9.4 per 1,000 live births, and for blacks 18.4 per 1,000 live births. The Commitee is concerned, however, that despite the proven importance and cost effectiveness of pre-natal care, the United States continues to experience a relatively high incidence of infant mortality and childhood disabilities. Between

1950 and 1985, the U.S., which ranked 6th amongst 20 industralized nations in infant mortality, fell to a tie for last place. In 1985, the U.S. ranked 19th overall in the world in infant mortality. When only white births are considered the nation placed 14th, behind Hong Kong and Singapore. When black rates are considered the nation ranked 28th behind Cuba, Czechoslovakia and Hungary and tied with Costa Rica.

The Committee is committed to aggressive action to meet the Surgeon General's 1990 maternal and child health objectives. Most notably, those objectives relating to prenatal care improvements, reductions in low birthweight, mortality reduction for minority infants and overall postneonatal mortality reductions are of great concern. The Committee recognizes that action is necessary to reduce the thousands of unnecessary low birthweight births and hundreds of preventable infant deaths.

Community and Migrant Health Centers have long played a pivotal role in the nation's effort to reduce infant mortality. Located in medically underserved areas suffering a high incidence of poverty and infant mortality, studies show that health centers have had a significant impact on their communities' infant mortality rates. The comprehensive services which health centers offer, and their ability to gain needed hospital access for high risk women and infants, contributed heavily to the 50 percent reduction in infant mortality which occurred between 1965 and 1980.

The need for strong health center maternal and infant health programs has never been greater. In 1985, 14.5 million women of childbearing age were uninsured for maternity care, and two-thirds of these (9.6 million) were completed uninsured. More than 11 million children were uninsured. One in every five babies born in 1985 was completely uninsured. Between two-thirds and three-quarters of all uninsured women and children have family incomes below 200 percent of the federal poverty level and thus are unable to pay directly for even basic health care.

Moreover, the problem appears to be growing worse. Census data show that between 1985 and 1986, the number of uninsured Americans grew from 35 million to 37 million—a nearly six percent increases. Despite the largest peacetime recovery in U.S. history, the number of uninsured Americans continues to grow.

In 1986, Community and Migrant Health Centers provided maternity care to 120,000 pregnant women and pediatric care to at least as many infants. However, the OTA found that despite extraordinary growth in the number of low income and uninsured women and children during the 1980s, health center funds in real dollar terms declined by one-third between 1980 and 1984 alone. Since 1984, real dollar declines have grown further. These real dollar declines mean that at the very time when health center services have been needed most, their ability to respond to this need has been severely reduced.

In 1987, the Committee and the Senate approved legislation (S. 1441) to increase the programs' fiscal year 1988 authorization levels to provide for the immediate expansion of services to high risk women and children in order to reduce infant mortality. Although that legislation has not yet been enacted, the Committee is pleased to note that the Congress, in its fiscal year 1988 appropriations, did

provide funds for this new initiative. The Committee bill would continue and expand this special infant mortality effort over the next three years.

The purpose of this effort is to contribute directly to the reduction of perinatal mortality/morbidity rates, improve pregnancy outcomes and enable underserved areas to reach the Surgeon General's 1990 infant health goals by:

Improving pregnant women's and children's access to needed health services;

Enhancing the ability of C/MHCs to provide comprehensive case-managed perinatal ambulatory care services;

Enriching the services of C/MHCs through addition of staff for outreach, health care, nutrition education, and the like;

Development, or expansion, of service delivery systems for women and infants, including contractual arrangements with community obstetricians to serve patients at health centers that do not have their own obstetrical staff, and formal referral arrangements with local hospitals and with regional medical centers furnishing level II or III perinatal services; and

Better coordination of services between C/MHCs and other local public and private providers of medical, health and health-related services.

Under the provisions of the bill, the fiscal year 1989 appropriatios for CHCs that exceed $435 million, and the appropriations for Migrant Health that exceed $47.4 million, would be used for special grants to enhance the ability of the C/MHC programs to reach and serve high risk pregnant women, infants and children, through a combination of:

Development of new service delivery systems in identified communities where no C/MHC services now exist, to include perinatal care as part of the scope of services;

Expansion of service delivery capacity in existing C/MHCs, to provide delivery of services through expanded or additional sites in identified communities where current services are insufficient to meet needs;

Enhancement of current primary and supplemental services at existing C/MHCs to improve quality and scope of care provided to pregnant women, infants and children; or

Better coordination with other statewide services in order to enhance perinatal and pediatric delivery systems.

The Committee believes that using these funds to establish new centers or expand existing centers (through the addition of new service sites or new personnel, or both) will improve the availability of comprehensive, high quality maternal and infant care. In many high risk areas of the country, pregnant women are unable to find accessible and affordable prenatal care. Following birth, basic care for an infant's health needs (particularly in the case of high risk infants) may be equally difficult to locate. The Committee has special concern about areas of the country and States where infant mortality remains unusually high and where no community services are available. Southern States, border States along the U.S.-Mexico border, and frontier areas are identified by the Committee as areas meriting special attention for establishment of new facilities to improve access to care.

The Committee does expect that these new activities will assist high risk pregnant women, infants, and children. It is not, however, the Committee's intent, when funds are used to develop new centers or to establish new service sites through existing grantees, that these services should be restricted to pregnant women and infants.

The Committee does not intend that these funds be used to supplant ongoing state, local, or private support for the operation of existing perinatal care systems. Rather, the clear intent is that current health centers' capacity will be expanded through use of these funds.

These funds should also be made available to meet the costs of hiring additional medical, nursing, ancillary service, or case management personnel, or the costs associated with deploying staff at additional service sites, in order to better serve high risk pregnant women, infants and children.

It is the Committee's intent that development of new service delivery sites, whether through new starts (new grantees) or expansions (existing grantees) should be limited to identified localities which are medically underserved areas and which (whether for the general population or for racial or socioeconomic population subgroups) have a high or increasing rate of maternal, infant, or child health mortality or morbidity, including low birthweight.

For purposes of this bill, a high incidence of infant mortality is considered to be a rate which is greater than the infant mortality rates for the Nation, either as a whole or by race. In 1985, these rates were 10.6 infant deaths per 1,000 live births for all races, 9.3 per 1,000 for whites, and 18.2 per 1,000 for blacks. The Secretary, in making grants to projects serving other populations, such as Native Americans or Hispanics, should apply appropriate mortality rates for infants from each racial and ethnic minority, as developed by the National Center for Health Statistics. The Secretary should also give special consideration to areas in which the neonatal (birth to 28 days) or postneonatal (29 days to 1 year) infant mortality rates are higher than average, even though the overall infant mortality rate may be below the national average, as well as to areas with high concentrations of minority populations other than blacks. The Secretary should also give special consideration to areas wose infant mortality rate may be below the overall national average, but which have seen a dramatic increase in the incidence of infant mortality in recently periods.

Further, it is the Committee's intent that the Secretary make grants designed to enhance the scope and depth of primary and supplemental services offered by health centers pursuant to Sections 329 and 330 of the Act. This is especially important in the case of high risk pregnant women and infants, because the development of new technology and risk assessment techniques has dramatically outstripped centers' service capacity and grant levels. The Committee also intends that centers have the latitude to use these enhancement funds toward meeting their maternity and infant patients' hospitalization needs when, in the opinion of the health centers, hospitalization is essential to patient management and other financial resources are unavailable.

The Committee also intends that these additional appropriations be used to fund outreach and patient management services as well as special perinatal/infant care coordination projects between health centers and other agencies, institutions, and organizations that are crucial to successful management of pregnant women and infants. These services are defined as activities desgined to get women and children into care as early as possible, keep them in care, and make the health care system responsive to their needs. Specific services (many of which are already recognized as primary and supplemental services) include:

Casefinding, including the use of lay and professional outreach workers;

Translation assistance as well as other activities that reduce barriers to care such as transportation;

Patient and provider education regarding what medical and health services, assistance and resources are available in a community and how to gain access to them;

Parenting and perinatal patient education classes; and

Coordination of services with other perinatal care providers.

The Committee recognizes that these services can best be provided through employment of additional staff, especially lay outreach workers, and through the development of a "team approach" involving such outreach workers and the centers' clinical staff. It is the provision of these types of services which has made the C/MHC programs unique and particularly successful in effectively caring for high risk, medically underserved populations.

In addition, the Committee supports the use of these funds for centers to improve the quality and responsiveness of regionalized perinatal care services for their patients. Centers might accomplish these objectives through a variety of activities. These might include: developing or improving transportation services which would be suitable for high risk mothers and infants; training staff to provide better risk assessment, more appropriate referral, or better follow-up care; developing improved communication systems between centers and more specialized medical centers; providing prenatal outreach to better ensure timely entry into appropriate care; and developing a system for accelerated eligibility into public programs such as the Supplemental Food Program for Women, Infants and Children (WIC), Medicaid, and other indigent health care financing programs. In the last example, it is not the Committee's intent that grant funds be used to pay the salaries of state or local public assistance eligibility workers. These grants would be used to develop coordination and referral arrangements between health centers and other agencies, institutions and organizations within their communities that are crucial to the successful management of pregnant women and infants.

Because of the continuing problems of perinatal mortality and morbidity, it is the Committee's intent that additional funding for these activities be made avaialble as soon as possible. Therefore, the Committee urges the establishment of a streamlined application and approval process with minimal reporting requirements. In this way, grant funding can be expedited and services made available in a timely basis.

Because of the importance of this activity, the Committee expects the Secretary to evaluate the effect of these new efforts, although they should not be subject to formal demonstration evaluation procedures. In order to evaluate the success of these efforts in reducing the incidence of infant mortality, the Committee believes that the following data should be collected; (1) the number of women and infants served; (2) in the case of pregnant women, the trimester of initiation of prenatal care; and (3) the conditions disclosed among pregnant women and infants served. This information should be reported to the Secretary annually, in conjunction with other reports already required of CHC and MH grantees. The Secretary shall aggregate and analyze the information provided, and issue a public report describing the analysis and findings.

B. CHANGES IN BASIC STATUTORY PROVISIONS

1. Health Center Services

The Committee bill would establish, as a new primary (required) health service at C/MHCs, Patient Case Management Services (including outreach, counseling, referral, and followup). The Committee is aware that these services—which were once an integral part of a typical health center's service package—are today offered by fewer than one-third of all C/MHCs. In most cases, these services were either reduced or eliminated due to funding constraints. The Committee wishes to note that these very services have been cited by numerous independent experts—most recently the Institute of Medicine in its report on *Preventing Low Birthweight*—as being particularly important in serving high-risk, hard-to-reach populations, such as pregnant women, children, the elderly, AIDS patients, migrant farmworkers and new immigrants.

The Committee wishes to stipulate, however, that it does not intend to require that federal support be shifted away from direct medical and health services in order to support these added services. The Committee recognizes that these medical and health services have been critical to the medical management of their patients, especially those persons who are at high-risk. Rather, it is the Committee's desire that, as additional funds are made available for these programs through future appropriations, priority should be given to the development or restoration of the patient case management services at existing health centers.

The Committee also recognizes that C/MHCs must have the ability to tailor their services to the unique health needs of their patients and local communities. The Committee bill would accomplish this by adding "other appropriate health services" to the current list of supplemental (optional) services. This provision would give C/MHCs, the flexibility to respond to the changing social and epidemiological characteristics of their patient populations. For example, the current list of primary and supplemental services does not mention such services as substance abuse, services to the elderly (such as adult day care, respite care, or hospice care), or referral to medical specialty services, such as neurology and oncology. Addition of this provision to the statutory language would remedy this problem.

Under current law, C/MHCs are encouraged to apply for and provide certain "priority" supplemental (optional) services, including home health, dental, public health, health education and environmental health services. The Committee believes that, while the intent of the provision is appropriate, the current list of "priority" supplemental health services is too limited. For example, while some communities may need home health or dental services, others may need vision care or mental health services. The Committee bill would remedy this problem by eliminating the current limitation, and extending application of the provision to all supplemental health services.

2. Designation of Areas Eligible for Assistance

The bill would prohibit the removal of a Migrant Health-funded project or program's "high impact area" designation until the project or program has a reasonable opportunity to respond with data and information supporting the continuation of the designation. The Committee has two reasons for adding this requirement. First, inasmuch as the high impact area designation affords programs and projects a key priority for funding under this program, principles of fairness warrant the provision of some procedural protections before eliminating any program or project's designation. Second, the Committee feels it imperative to insure that any decision by the Secretary to remove a designation is fully informed. The Committee believes that a program or project often may have access to data and information regarding the population it serves which is more accurate or more comprehensive than what is available to the Secretary through other channels.

Since 1976, eligibility for Community Health Center grants has been restricted to entities serving designated medically underserved areas with high rates of poverty, health manpower shortages, and poor health indicators (especially high infant mortality). Designation is accomplished through comparison of an area's statistical data against established criteria, with priority for grant support accorded to those areas showing greatest need. Because changes in these criteria can critically affect a health center's funding priority, not to mention its fundamental eligibility, the Committee finds it appropriate to have the Secretary comply with the notice and comment requirements of the Administrative Procedure Act in connection with any proposed changes to the criteria.

3. Use of Grant Funds for Expansion and Construction

It has come to the Committee's attention that the Department's interpretation of current law authorizing funding for acquisition and modernization of existing buildings has been very narrow, resulting in a refusal to support (even minimally) critically needed expansion projects. Under this interpretation, facility renovations which do not modify the exterior walls of a facility currently used by a health center are fully acceptable, while *any* change to an exterior wall (for example, to add a wing with medical examining rooms or a small storage area, or an additional floor, to an existing facility) are wholly unacceptable. Thus, health centers that have experienced regular growth in patients or have added services are often faced with the Hobbesian choice of remaining in an inad-

equate facility or attempting to acquire a larger building—even if that means leaving their current neighborhood or community. Accordingly, in order to remove any doubt regarding the Secretary's discretion in this regard, the bill would authorize funding for expansion of existing facilities.

The bill would also allow support for construction of new facilities. The Committee intends through this amendment to afford the Secretary much needed flexibility to support the costs of a variety of capital projects, particularly in rural areas and blighted urban areas where neither existing facilities are available for acquisition nor alternatives for financing facility construction and refurbishing exist. The Committee expects, however, that this authority will be exercised only where the center's need for such support and the absence of other resources is demonstrated. The Committee does not intend, in either instance, that limited grant dollars for health services be redirected to capital projects.

In order to facilitate needed renovations and conserve grant funds, the Committee expects health centers to make every effort to utilize available commercial financial sources for facility acquisition, construction, modernization and expansion needs. In this regard, the Committee expects the Secretary to take the necessary steps to authorize the subordination of current Federal interests in such facilities to enable the health centers greater access to commercial financial markets.

4. Computation of Grant Amounts and Excess Revenues

The bill provides that the amount of any grant may not exceed the amount by which the total of fees, premiums and third party reimbursements "(as well as State, local and other operation funding)" . . . exceeds the C/MHCs overall costs of operation. State, local or other operational funding that adds to the ability of a health center to provide primary health care services should be taken into account in computing the appropriate amount of a grant award.

It is not the Committee's intent, however, to require that State, local or other operational funding be subject both to the requirements of the funding source and also to HHS' rules and policies governing the expenditure of federal funds or income derived therefrom. The burden placed on health centers by having them comply with two sets of requirements would be unfair and would place them in an untenable position.

The Committee is further advised that C/MHCs and Federal officials have been confused about the extent to which health centers must include in their grant budgets those State, local and other funds not directly targeted to C/MHC operations. Such funds should not be included in the budget.

The Committee also wishes to stress that Federal grant funds are "last dollar" to other funds available to health centers for the provision of comprehensive health services to medically underserved populations. The Committee finds totally unacceptable the position apparently taken by some states that, because health centers are obligated to serve everyone, grant funds are available to reduce the level of reimbursement paid for services to Medicaid recipients.

While the Committee expects federal, state, and local granting agencies to cooperate in covering the full costs of their respective programs, health centers as a last resort may continue to use their federal grant funds to meet their full costs of serving eligible individuals where other grants fail to cover such costs.

In 1978, the CHC and MH statutes were amended to include incentives for health centers to increase collections for services from all sources. To this end, the statutes required the Secretary to permit centers to retain revenues from fees, premiums and third-party reimbursements exceeding realistic revenue projections, so long as those revenues were used for a specified set of activities to further the objectives of the program.

The Committee is distressed to learn that the intended incentives were largely ignored for several years, and have more recently been undermined in a variety of ways. Many C/MHCs have been allowed to keep only 50 percent of the excess (the minimum they were statutorily entitled to retain)—regardless of the merits of their proposals for using the additional excess. In other instances, the Department has insisted on unrealistically high-income projections, making it impossible for centers to generate any excess revenues.

The Committee reaffirms its belief that C/MHCs should be given an incentive to maximize income from other sources. The bill accordingly would permit health centers to keep 100 percent of any excess. The Committee stresses its intent that unduly high income projections should not be forced on centers and that the projections should instead be realistically developed, based primarily on each center's collection experience over the prior several years. Any excess income should be used only for the purposes specified in the statute.

5. Hearings With Respect to Adverse Grant Decisions

The Community and Migrant Health Center programs have been in existence for nearly twenty-five years. Most health centers have been in operation for more than a decade. The Boards, staff and communities served by these centers are obviously deserving of protection against arbitrary or capricious terminations of existing grants or denials of applications for future grant awards. Accordingly, the bill would provide that existing grantees can neither have their current or future funding terminated, in whole or in part, without an on-the-record hearing at which the affected organization will have the opportunity to demonstate that the termination is unwarranted.

The protection afforded against termination of current grants is virtually the same as a protection that already exists under the Secretary's regulations, although the process would be slightly more formal. The protection afforded with respect to denials of applications for future funding is, however, new. For this new protection, the Committee has specified that the Administrator of the Health Resources and Services Administration (HRSA) is to be the final decision-maker. The Committee is mindful that the reasons for termination of existing grants typically relate to serious problems in financial management, while the reasons for a denial of a continuation application will probably be for programmatic rather

than fiscal reasons. Thus, it seems appropriate for a programmatic official to be the one who makes the final decision.

The Committee does not expect the HRSA Administrator actually to preside at hearings. Rather, the Committee expects that the Administrator will delegate this responsibility to an impartial official and generally oversee the results either by treating the official's decision as a "recommendation" or by allowing the decision to become final after he has reviewed it.

The Committee wishes to provide the Secretary with the latitude to make less than substantial funding reductions to meet needs that arise in other locations. Accordingly, the Committee intends that the Secretary should be permitted to reduce current funding levels by as much as ten percent without triggering an applicant's right to a hearing (as long as the reduction in any several-year period does not exceed fifteen percent). The funding level against which funding denials are to be measured should not include special one-time awards or reductions occasioned solely as a consequence of cuts in available appropriations.

6. Administration of Health Center Programs

The Committee is concerned by persistent reports of serious inconsistencies in important policy interpretations by various HHS regional offices, of unexplained funding reductions, of cash flow crises occasioned by grant award delays of several weeks or even months, and so on. In an effort to bring uniformity, equity and greater accountability in Federal oversight of this program, the Committee has determined that the Secretary's authority to enter into, modify, or issue health center grants should be delegated to the central office within the Health Resources and Services Administration. The Committee hopes that centralized administration will ensure consistent and even-handed implementation of policy and priorities across the various HHS regions. Although the basic monitoring functions of HHS regional offices would remain intact, the Committee expects all final decisions to be centrally made.

7. Other Committee Concerns

The Committee recognizes the wisdom of current law provisions which require that Community and Migrant Health Centers be governed by a policy board composed of representatives of the community, at least 51 percent of whom are users of the center's services. These policy boards are required, by Federal mandate, to provide policy leadership and guidance to the health center's management and clinical staff, and to monitor and evaluate all elements of the center's performance. Federal managers should respect the role and responsibilities of these governing boards, as well as the need for continuity in board membership to assure appropriate policy oversight, and should provide them with the necessary guidance, technical assistance, and training to assist them in fulfilling their responsibilities.

The Committee is also aware of existing difficulties for the governing boards of many Migrant Health Centers (Section 329) in meeting the current regulatory requirement for regular board meetings, particularly when their migrant farmworker board members have left the area to follow the agricultural harvest and

cannot attend meetings. To remedy this situation, the Committee recommends that health centers endeavor to have a good mix of both migrant farmworkers who can participate in the board during the harvest season, and seasonal farmworkers, who are generally year-round residents of the local community.

The Committee is aware that, with the enactment of the Immigration Reform and Control Act of 1986 (IRCA), newly legalized immigrants and special agricultural workers (SAWs) will likely become eligible for the services of C/MHCs. The Committee believes that Community and Migrant Health Centers across the country have an important role to play in the implementation of the Immigration Reform and Control Act. Many health centers have already been designated as "civil surgeons", to provide the medical examinations necessary for persons seeking legalization. Subsequently, health centers will serve as an entry point for new immigrants into an established system of managed care. The Committee, therefore, recommends that grant funds be made available, on a reasonable basis, to serve these new populations. It also strongly encourages Community and Migrant Health Centers to access the funds provided by IRCA through the State Legalization Impact Assistance Grants (SLIAG) program. These funds are allocated to state governments to reimburse costs incurred in providing public assistance, public health assistance, and educational assistance to legalized aliens. The Committee believes that states should recognize the C/MHCs as preferred providers in distributing SLIAG funds, especially in rural or urban areas where no other providers exist.

8. Frontier Areas

In recent years, as the public policy debate on the problems of financing and delivering health care services in rural areas has unfolded, the Committee has become aware of the special problems inherent in attempting to develop and operate health care delivery systems in the most sparsely populated rural areas of America. Borrowing from a DHHS-funded Task Force, the Committee has used the term "frontier" to describe these areas, which are defined as those with a population density of no more than six persons per square mile, spread over a broad geographical area (generally an entire county or multiple counties, although a sub-county area or adjoining parts of two or more counties would also fit this definition).

According to the 1980 U.S. Census, there were at least 382 counties, with a population of nearly 2.9 million persons, which would meet the above definition. These areas are principally found in 20 Western states, and encompass 45 percent of the U.S. land area.

In addition to having sparse populations, these areas tend to be geographically isolated, have a fragile economic base and offer limited health services. The geographic isolation and population sparcity of such areas militate against traditional approaches to development and efficient operation of ambulatory health care delivery systems. The small size of such systems results in inherent cost inefficiencies, decreased productivity of clinical providers, difficulty in arranging referrals, and difficulties in recruiting and retaining high quality clinical and management personnel.

Despite the fact that most of the residents of the areas are obviously medically underserved, very few CHCs (or even free-standing National Health Service Corps sites) are currently receiving federal support in such areas. In fiscal year 1986, only 17 of the 648 CHC grantees were located in frontier areas as were 38 or 3,127 NHSC assignees. Morever, the federal expectations and requirements of these sites were the same as those for much larger rural, and even urban, CHC sites. Although the statute permits considerable latitude in designing appropriate CHC systems, the federal program managers appear to have allowed little or no flexibility in permitting grantees to tailor their delivery systems to local needs or to the unique characteristics of these areas.

To remedy this situation, the Committee intends the Secretary to:

Facilitate and support development of grant applications from frontier areas through use of federal technical assistance resources and appropriate state governmental entities and state associations of CHCs, supported under Section 330(f)(1).

Ensure that applications for grant support (whether for planning and development or for operations) are accorded fair and equitable treatment by federal reviewing authorities.

Develop criteria, standards, expectations and requirements for frontier sites which are relevant to their unique operational nature and are different from those for larger operations.

Within statutory limitations, explicitly allow and encourage creative approaches to systems development and operations.

Support and facilitate continued research, data development and efforts to promote a better understanding of the needs of frontier areas, incuding the work of the Frontier Health Task Force.

The Commitee wishes to clarify that it in no way intends to require the Secretary to ignore or waive current statutory requirements in this regard, nor does it expect the Secretary to support systems of care which are inadequate with respect to quality of care or completeness of care. For example, all frontier area CHCs must serve medically underserved populations and must meet the statute's requirements for governance, administration, fiscal and clinical systems and accountability, and the like. At the same time, such CHCs should be expected to make extensive use of mid-level providers, and to provide some services by referral arrangement rather than directly.

TITLE II—HEALTH SERVICES FOR THE HOMELESS

The legislation extends and makes needed minor revisions in the authorization for the Health Services for the Homeless Program under Title III of the Public Health Service Act. The Committee reaffirms the importance of continuing this new health services program for homeless persons in recognition of: the continuing, urgent, unmet health needs of the nation's homeless population; the Department's able performance in completing the timely funding of 109 projects in 43 states less than six months after enactment of the new law; and the Committee's desire to ensure continuation of services through the currently-funded projects, and de-

velopment of new projects in communities with high need that did not receive funding in the first cycle.

1. Non-Federal Matching Funds Requirement

The Committee bill would continue the current requirement for a nonfederal match of $1 for each $3 of federal support for the first year of grant support, and would increase the non-federal match requirement to $1 for each $2 in federal support for all continuation grants. The Committee believes that the responsibility for providing services to the homeless is, and should be, shared between the public and private sectors, and among the federal and other levels of government.

The match requirement is intended to help communities generate these nonfederal contributions. The Committee appreciates the caution with which the Department has approached approval of match waivers in the first round of funding. The Committee also recognizes, however, that communities across the nation have varying capabilities to generate the nonfederal match, the Committee does not intend to deny health care services to homeless persons in the more severely economically distressed communities where applicants can demonstrate that they have made reasonable and diligent efforts to secure the full match requirement, but have fallen short. Therefore, the Committee has extended the eligibility to apply to the Secretary for a waiver of the non-federal match requirement to any nonprofit private entity. This provision is currently available only to nonprofit grantees funded under Section 330 of the PHS Act (Community Health Centers). Furthermore, to enable communities to contribute to the increased match, it is the Committee's intent that any health or health-related goods or services donated or provided with non-federal funds to homeless persons served by Section 340 projects are allowable as match, whether or not those goods or services can be supported by federal grant funds under Section 340. This can include, for example, respite care for Section 340 project patients even though such services may not be purchased with federal grant funds, and residential care provided to substance abusers following completion of inpatient detoxification treatment. The match must be supported from nonfederal sources with the exception of Community Development Block Grant funds administered by HUD, which, by federal regulation governing their use over a period of years, have been declared eligible for use as nonfederal match for federally-funded programs.

2. Clarification of Eligibility for Services

The legislation includes a provision allowing Section 340 projects to continue to provide health services to former homeless individuals for not more than twelve months after they have become residents in permanent housing. The intent of this provision is to permit projects the option to continue providing health services for particularly vulnerable individuals, especially those who are disabled and/or mentally ill, where such services are necessary to ensure that their transition to permanent housing is successful. The Committee expects, however, that projects will make every effort to transition such individuals into appropriate health care through existing systems as early as possible so that Section 340

projects can continue to target their services on the currently homeless.

The Committee wishes to clarify that the definition of homelessness contained in Section 340 (as amended) is the operative definition to be used in determining an individuals eligibility to receive services under this program. Individuals or families who lack housing or who reside in transitional housing pending location of more stable and permanent homes are considered eligible for health services under the definition provided in this legislation. Furthermore, while the Committee clearly intends that the "obviously" homeless such as those living on the streets and heating vents, in cars and abandoned buildings and in temporary shelters, are eligible to receive health services under Section 340, the Committee also recognizes that individuals and families who take temporary refuge with neighbors or friends due to inability to secure housing and who are seeking stable housing may also be considered homeless. This frequently may be the case in rural areas, for example, where there are no public or private emergency shelter facilities. Families or individuals, on the other hand, who share housing arrangements on a more or less stable and permanent basis, even in overcrowded conditions, generally are not considered homeless, although they may be inadequately housed. Section 340 projects are expected to make reasonable and justifiable judgments on a case-by-case basis as to whether the less obvious homeless are eligible for the program's services within the spirit and intent of the legislation. Furthermore, the Committee wishes to clarify that Section 340 is an outreach-oriented program intended to provide access to health care for homeless persons. It is understood that in the course of successful outreach in substantially homeless settings, such as soup kitchens, services occasionally will be provided to persons, who, though probably indigent, have housing of some sort. Such occasional service is considered incidental to the outreach-oriented nature of this program and should not be a matter of concern.

3. Clarification of Project Services

The Section 340 Health Services Program includes Primary Care and Substance Abuse services and optional provision of Mental Health Services. It should be noted that while the legislation indicates that "Primary Care Services" has the meaning given in Section 330(b)(1) of the Public Health Service Act, the Committee recognizes that this definition originally was developed for providers of health care for medically underserved populations rather than specifically for the homeless. Therefore, the Committee wishes to clarify that certain supplemental health services appropriate for and urgently needed by many homeless people but not specifically included in Section 330(b)(1) may also be provided with Section 340 support, including podiatry services, dental services (including dentures if necessary), and vision services. These supplemental services are optional, and should be provided where appropriate for patients' needs, subject to the availability of funds.

4. Authorization Levels

The Committee has provided an authorization of appropriations for this program at levels necessary to sustain currently-funded projects, to assist in continuing the services of the RWJ/PEW Memorial Trust-funded demonstration projects upon termination of foundation support later this year, and to enable development of services in a limited number of communities with homeless populations that did not receive funding in the first round. The Committee is aware that smaller cities and rural communities were initially discouraged from applying for support during the first round of funding, and that some larger cities did not apply for funding because of the short time frame provided for application. Developing coalitions and consortia that may transcend county lines, for example, can require considerable more time than the six-week period available to prepare applications in the first funding cycle. For example, approximately 40 cities with populations above 100,000 did not receive any support in the first round. Furthermore, to the extent possible, the Committee wishes to urge the Department to establish normal grant cycles that ensure adequate and stable funding throughout the winter months when homelessness presents the greatest threat to life and safety.

TITLE III—PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED DISEASES

The Committee recognizes that in the recent past, a greater percentage of resources in these programs have been, necessarily, expended on the AIDS epidemic. Unfortunately this has occurred at a time when the less well known but serious, and until recently difficult to diagnose, infection by Chlamydia has become an alarming problem. The Committee therefore authorizes $100,000,000 for fiscal year 1988 and such sums as necessary for 1989 and 1990. Language has been included specifically directing that programs for Chlamydia control, prevention and research be developed. It is the Committee's intent that a substantial part of the increase in the appropriation compared to last year be directed toward Chlamydia programs which are now possible because of the development of a relatively inexpensive diagnostic test for Chlamydia. The Committee also recognizes the need to increase the number of health professionals trained in the area of Sexually Transmitted Diseases and encourages expansion of the intramural and extramural CDC supported training programs.

V. Committee Action

The bill was considered before the Committee on March 2, 1988, and reported favorably without amendment by unanimous vote.

VI. Cost Estimate

U.S. Congress,
Congressional Budget Office,
Washington, DC, March 10, 1988.

Hon. Edward M. Kennedy,
Chairman, Committee on Labor and Human Resources,
U.S. Senate, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the attached cost estimate for the Family Health Services Amendments Act of 1988, as ordered reported by the Senate Committee on Labor and Human Resources on March 2, 1988.

If you wish further details on this estimate, please call me or have your staff contact Lori Housman (226–2820).

Sincerely,

James L. Blum,
Acting Director.

Attachment.

Basis of Estimate

This bill would revise and extend the assistance programs for primary health care, health services for the homeless, and the program for the prevention and control of sexually transmitted diseases. In fiscal year 1989, the bill would authorize $52.4 million for Migrant Health Centers, $500 million for Community Health Centers, and $100 million for the control of sexually transmitted diseases. The bill would authorize such sums as may be necessary for these activities for fiscal years 1990 and 1991. Authorization levels for fiscal years 1990 and 1991 were estimated by increasing the 1989 authorization by the appropriate inflators.

Health services for the homeless would be authorized at $61.2 million for fiscal year 1989, $63.6 million for fiscal year 1990, and $66.2 million for fiscal year 1991.

Authorizations are assumed to be fully appropriated at the beginning of each fiscal year. Outlays are estimated using spendout rates calculated by CBO on the basis of recent program data. This bill is subject to subsequent appropriations action.

6. Estimated cost to State and local government: Under the health services for the homeless provision, the Secretary of Health and Human Services could require nonprofit, private entities receiving grants to contribute not less than $1 in non-federal funds for each $3 of federal funds provided. For fiscal year 1989, if the entire $61.2 million authorized is appropriated, the maximum amount that applicants must make available would be $20.4 million. These non-federal funds could come from State and local governments.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Lori Housman.

10. Estimate approved by: James L. Blum, Assistant Director for Budget Analysis.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: None.

2. Bill title: Family Health Services Amendments Act of 1988.

3. Bill status: As ordered reported by the Senate Committee on Labor and Human Resources, March 2, 1988.

4. Bill purpose: The purpose of this bill is to amend title III of the Public Health Service Act of revise and extend the progams of assistance for primary health care, the progaam of health services for the homeless, and the program for the prevention and control of sexually transmitted diseases, and for other purposes.

5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1989	1990	1991	1992	1993
Migrant health centers:					
Authorization level	52.4	54.5	56.9	.....	.....
Estimated outlays	29.3	46.8	54.0	24.7	7.3
Community health centers:					
Authorization level	500.0	520.5	542.5	.....	.....
Estimated outlays	280.0	446.5	515.2	235.2	69.9
Health services for the homeless:					
Authorization level	61.2	63.6	66.2	.....	.....
Estimated outlays	34.3	54.6	62.9	28.7	8.5
Prevention and control of sexually transmitted diseases:					
Authorization level	100.0	104.4	108.8	.....	.....
Estimated outlays	61.0	84.7	102.3	41.5	19.4
Bill total:					
Authorization level	713.6	743.0	774.4	.....	.....
Estimated outlays	404.6	632.6	734.4	330.1	105.1

The costs of this bill would fall within budget function 550.

VII. Regulatory Impact Statement

The Committee has determined that there will be minimal or no increase in regulatory burden of paperwork imposed by this bill.

VIII. Section-by-Section Analysis

The bill provides that the Act may be cited as the "Family Health Services Amendments Act of 1988."

Section 2 of the bill provides that, except as otherwise provided, references to an amendment or repeal shall be considered to be made to a section or provision of this PHS Act.

TITLE I—PRIMARY HEALTH CENTERS

Migrant Health Centers

Section 101 of the bill amends section 329 of the PHS Act, which authorizes the Migrant Health Centers program. Section 101(a) amends the definition of the term "Migrant health center" in subsection (a)(1) of section 329 to include in the list of services provided by such a center, "patient case management services (including outreach, counseling, referral, and follow-up.)"

Section 101(b) of the bill amends the definition of the term "high impact area" in section 329(a)(5) of the Act to provide that the Secretary may not remove a project or program's 'high impact area' designation unless and until the project or program is afforded reasonable notice and an opportunity to provide data and information in support of continuing such designation.

Section 101(c) of the bill amends the definition of the term "supplemental health services" in section 329(a)(7) of the Act to include in that definition "other services appropriate to meet the health needs of the service are population."

Section 101(d) of the bill amends section 329(c)(1) of the Act authorizing the use of migrant health center project grants for expansion of existing buildings and construction of new facilities.

Section 101(e) of the bill amends section 329(d)(2) of the Act to provide that the costs of operation of a migrant health center for which a grant may be made shall include the cost of expanding existing buildings and construction of new facilities.

Section 101(f) of the bill amends section 329(d)(4)(A) of the Act, which provides for the determination of the amount of a migrant health center grant. Under the bill, the amount of the grant may not exceed the amount by which the costs of operation of a center for a fiscal year exceeds the total of the fees, premiums, and third party reimbursements (as well as State, local, and other operational funding), which the center may reasonably be expected to receive in the year.

Section 101(f) of the bill also amends section 329(d)(4)(B) of the Act, which provides for centers to retain one-half of any excess in money collected from patient fees, premiums, and third party reimbursement over the amount projected at the beginning of the year. These monies may be used by the center to expand and improve its services, increase the number of persons served, construct and modernize its facilities, improve its administration, and establish the financial reserve required to furnish services on a prepaid basis. Under this bill, a center shall be entitled to retain the entire additional amount of fees, premiums, and other third party reimbursements as the center will use to expand and improve services, increase number of persons served, construct and modernize facilities, improve administration, and establish required financial reserve.

Section 101(g) of the bill amends section 329(f)(3)(i) of the Act, which requires a migrant health center to prepare a schedule of fees and payments for the provision of its services. The amendment in this bill requires this schedule to be consistent with locally prevailing rates or charges.

Section 101(h) of the bill amends section 329(h) of the Act, which authorizes appropriations for the migrant health centers program. This provision authorizes appropriations for section 329 of $52.4 million in FY 1989 and such sums as are necessary in each of FY 1990 and FY 1991. Anything appropriated over $47.4 million for FY 1989, $51.4 million for FY 1990, or $55 million for FY 1991, must be made available for grants to migrant health centers for the provision of services for the reduction of the incidence of infant mortality, and the development and coordination of referral arrangements between migrant health centers and entities for the health man-

agement of infants and pregnant women. In making such grants, the Secretary shall give priority to migrant health centers providing services in any catchment area in which there is a substantial incidence of infant mortality or in which there is a significant increase in the incidence of infant mortality.

Section 101(h) of the bill also amends section 329(h) of the Act to provide for procedures to terminate grants under this authority for migrant health center operating costs. These grants cannot be terminated unless there is cause and the program or project has first been given reasonable notice and opportunity for a hearing on the record. In addition, no grant application from a program or project that received a grant in the previous year may be denied without cause and unless the program or project has first been given reasonable notice and opportunity for a hearing on the record before the Administrator of the Health Resources and Services Administration (HRSA).

Community Health Centers

Section 102 of the bill amends section 330 of the PHS, which provides the authority for the Community Health Centers program. Section 102(a) of the bill amends the definition of the term "community health center" to include in the list of services such a center provides, "patient case management services (including outreach, counseling, referral, and follow-up)."

Section 102(b) of the bill amends the definition of the term "supplemental health services" to include in that definition "other services appropriate to meet the health needs of the service area population."

Section 102(c) of the bill amends section 330(b) of the Act to prohibit the Secretary from changing the criteria established to determine the specific shortages of personal health services of an area or population group unless public notice and an opportunity for comment on proposed changes in accordance with section 553 of title 5, United States Code been offered.

Section 102(d) of the bill amends section 330(c) of the Act to authorize the use of community health center grants to expand existing buildings and construct new facilities.

Section 102(e) of the bill amends section 330(d)(2) of the Act to provide that grants made for community health center operating costs can be used for the costs of expanding existing buildings and construction of new facilities.

Section 102(f) of the bill amends section 330(d)(4)(A) of the Act, which provides for the determination of the amount of a community health center grant. Under the bill, the amount of the grant may not exceed the amount by which costs of operation in a fiscal year exceed the total of the fees, premiums, and third party reimbursements (as well as State, local, and other operational funding), which the center may reasonably be expected to receive in the year.

Section 102(f) also amends section 330(d)(4)(B) of the Act, which provides for centers to retain one-half of any excess in money collected from patient fees, premiums, and third party reimbursement over the amount projected at the beginning of the year. These monies may be used by the center to expand and improve its serv-

ices, increase the number of persons served, construct and modernize its facilities, improve its administration, and establish the financial reserve required to furnish services on a prepaid basis. Under this bill, a center shall be entitled to retain as much of the entire additional amount of fees, premiums, and other third party reimbursements as the center will use to expand and improve services, increase number of persons served, construct and modernize facilities, improve administration, and establish required financial reserve.

Section 102(g) of the bill amends section 330(e)(3)(F)(i) of the Act, which requires a community health center to prepare a schedule of fees and payments for the provision of its services. The amendment in this bill requires this schedule to be consistent with locally prevailing rates or charges.

Section 102(h) of the bill amends section 330(g) of the Act, which authorizes appropriations for this community health centers program. The bill authorizes appropriations of $500 million for FY 1989 and such sums as may be necessary for each of FY 1990 and FY 1991. Anything appropriated over $435 million for FY 1989, $465 million for FY 1990, and $495 million for FY 1991, must be made available for grants to community health centers for services to reduce the incidence of infant mortality, and to develop and coordinate referral arrangements between community health centers and entities for the medical management of infants and pregnant women. In making these grants, the Secretary must give priority to centers providing services to any medically underserved population with a substantial incidence of infant mortality or which has experienced a significant increase in the incidence of infant mortality.

Section 102(h) of the bill also amends section 330(g) of the Act to provide for procedures to terminate grants under this authority to a community health center. Such a grant may not be terminated without cause and unless the center or project has first been given reasonable notice and opportunity for a hearing on the record. In addition, no grant application from a program or project that received a grant in the previous year may be denied without cause and unless the program or project has first been given reasonable notice and opportunity for a hearing on the record before the Administrator of the Health Resources and Services Administration (HRSA).

Section 103 of the bill amends section 330 to require the Secretary, in making grants for community health center, to give special consideration to the unique needs of frontier areas.

Section 104 of the bill adds a new section 330A to the Act to authorize the Secretary to delegate the authority to administer the programs under sections 329 and 330 to any office within the PHS, except that the authority to enter into, modify, or issue approvals with respect to grants or contracts, may be delegated only within the central office of HRSA.

TITLE II—HEALTH SERVICES FOR THE HOMELESS

Section 201 of the bill amends section 340 of the PHS, which was created by the Stewart B. McKinney Homeless Assistance Act of 1987 and which authorizes a grant program for health services for

the homeless. Section 201(a) of the bill amends section 340(e) providing for matching funds under this program. Under current law, a grant applicant must agree to make available matching funds equal to not less than $1 (in cash or in kind) for each $3 of Federal funds provided in the grant. The bill extends this matching requirement to grant payments made for any subsequent fiscal year. This amendment shall take effect October 1, 1989. Under section 340, the Secretary may waive the matching requirement if the applicant is a nonprofit private grantee under section 330 and the Secretary determines that it is not feasible for the applicant to comply with such requirement. Section 201 of the bill amends this waiver to apply to any nonprofit private entity.

Section 202 of the bill amends section 340 of the Act to provide that, if a grantee under this authority has provided services to a homeless individual and that individual is no longer homeless as a result of becoming a resident in permanent housing, the grantee may continue to provide services to such individual for no more than 12 months.

Section 203(a) of the bill amends section 340(o)(2) (as redesignated by this bill) to provide that the Secretary may expend not more than $2 million in a fiscal year for technical assistance under this program. Section 203(b) of the bill amends the definition of "homeless individual" in section 340 to include an individual who is a resident in transitional housing.

Section 204 of the bill authorizes appropriations of $61.2 million for FY 1989, $63.6 million for FY 1990, and $66.2 million for FY 1991 for the grant program of health services for the homeless authorized in section 340.

TITLE III—PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED DISEASES

Section 301 of the bill amends section 318 of the Act to authorize appropriations of $100 million for FY 1988 and such sums as may be necessary for each of FY 1989 and FY 1990 for projects and programs for the prevention and control of STD. This section requires the Secretary to obligate not less than 10 percent of the amount appropriated for a fiscal year for grants for research, demonstration projects, public information and eduction programs for the prevention and control of such diseases, and for education, training, and clinical skills improvement activities for health professionals. The section also provides that grants under section 318 shall include grants for the prevention and control of, and grants for research and other projects, programs, and activities relating to, chlamydia.

IX. Changes in Existing Law

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * * * *

TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

* * * * * * *

PART B—FEDERAL-STATE COOPERATION

PROJECTS AND PROGRAMS FOR THE PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED DISEASES AND ACQUIRED IMMUNE DEFICIENCY SYNDROME

SEC. 318. (a)-(d) * * *

(e)[(1) For the purpose of making grants under subsections (b), (c), and (d) there are authorized to be appropriated $45,000,000 for the fiscal year ending September 30, 1979, $51,500,000 for the fiscal year ending September 30, 1980, $59,000,000 for the fiscal year ending September 30, 1981, $40,000,000 for the fiscal year ending September 30, 1982, $46,500,000 for the fiscal year ending September 30, 1983, $50,000,000 for the fiscal year ending September 30, 1984, $57,000,000 for the fiscal year ending September 30, 1985, $62,500,000 for the fiscal year ending September 30, 1986, and $68,000,000 for the fiscal year ending September 30, 1987. For grants under subsection (b) in any fiscal year, the Secretary shall obligate not less than 10 per centum of the amount appropriated for such fiscal year under the preceding sentence. Grants made under subsection (b), (c), or (d) of this section shall be made on such terms and conditions as the Secretary finds necessary to carry out the purposes of such subsection, and payments under any such grants shall be made in advance or by way of reimbursement and in such installments as the Secretary finds necessary. If the appropriations under the first sentence for fiscal year 1985 exceed $50,000,000, one-half of the amount in excess of $50,000,000 shall be made available for grants under subsection (d); if the appropriations under the first sentence for fiscal year 1986 exceed $52,500,000, one-half of the amount in excess of $52,500,000 shall be made available for such grants; and if the appropriations under the first sentence for fiscal year 1987 exceed $55,000,000, one-half of the amount in excess of $55,000,000 shall be made available for such grants.]

(1)(A) For grants under subsections (b), (c), and (d), there are authorized to be appropriated $100,000,000 for fiscal year 1988 and such sums as may be necessary for each of the fiscal years 1989 and 1990.

(B) For grants under subsection (b) for any fiscal year, the Secretary shall obligate not less than 10 percent of the total amount appropriated for such fiscal year under subparagraph (A).

(C) Grants made under subsection (b), (c), or (d) shall be made under such terms and conditions as the Secretary finds necessary to carry out the purposes of such subsection, and payments under any

such grants shall be made in advance by way of reimbursement and in such installments as the Secretary finds necessary.

* * * * * * *

(h) Grants under subsections (b) and (c) shall include grants for the prevention and control of, and grants for research and other projects, and programs, and activities relating to, chlamydia.

* * * * * * *

PART D—PRIMARY HEALTH CARE

Subpart I—Primary Health Centers

MIGRANT HEALTH

SEC. 329. (a) For purposes of this section:

(1) The term "migrant health center" means an entity which either through its staff and supporting resources or through contracts or cooperative arrangements with other public or private entities provides—

(A) primary health services,

(B) as may be appropriate for particular centers, supplemental health services necessary for the adequate support of primary health services,

(C) referral to providers of supplemental health services and payment, as appropriate and feasible, for their provision of such services.

(D) environmental health services, including, as may be appropriate for particular centers (as determined by the centers), the detection and alleviation of unhealthful conditions associated with water supply, sewage treatment, solid waste disposal, rodent and parasitic infestation, field sanitation, housing, and other environmental factors related to health,

(E) as may be appropriate for particular centers (as determined by the centers), infections and parasitic disease screening and control,

(F) as may be appropriate for particular centers, accident prevention programs, including prevention of excessive pesticide exposure, [and]

(G) information on the availability and proper use of health services and services which promote and facilitate optimal use of health services, including, if a substantial number of the individuals in the population served by a center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals, *and*

(H) patient case management services (including outreach, counseling, referral, and follow-up),

for migratory agricultural workers, seasonal agricultural workers, and the members of the families of such migratory and seasonal workers, within the area it serves (referred to in this section as a "catchment area") and individuals who have previously been migratory agricultural workers but can no longer meet the requirements of paragraph (2) of this subsection because of age or disability and members of their families within the area it serves.

(2) The term "migratory agricultural worker" means an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last twenty-four months, and who establishes for the purposes of such employment a temporary abode.

(3) The term "seasonal agricultural workers" means an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural workers.

(4) The term "agriculture" means farming in all its branches, including—

(A) cultivation and tillage of the soil,

(B) the production, cultivation, growing, and harvesting of any commodity grown on, in, or as an adjunct to or part of a commodity grown in or on, the land, and

(C) any practice (including preparation and processing for market and delivery to storage or to market or to carriers for transportation to market) performed by a farmer or on a farm incident to or in conjunction with an activity described in subparagraphs (B).

(5) The term "high impact area" means a health service area or other area which has not less than four thousand migratory agricultural workers and seasonal agricultural workers residing within its boundaries for more than two months in any calendar year. In computing the number of workers residing in an area, there shall be included as workers the members of the families of such workers. *The Secretary may not remove a project or program's high impact area designation unless and until the project or program is afforded reasonable notice and an opportunity to provide data and information in support of continuing such designation.*

(6) The term "primary health services" means—

(A) services of physicians and, where feasible, services of physicians' assistants and nurse clinicians;

(B) diagnostic laboratory and radiologic services;

(C) preventive health services (including children's eye and ear examinations to determine the need for vision and hearing correction, perinatal services, well child services, and family planning services);

(D) emergency medical services;

(E) transportation services as required for adequate patient care;

(F) preventive dental services; and

(G) pharmaceutical services, as may be appropriate for particular centers.

(7) The term "supplemental health services" means services which are not including as primary health services and which are—

(A) hospital services;

(B) home health services;

(C) extended care facility services;

(D) rehabilitative services (including physical therapy) and long-term physical medicine;

(E) mental health services;

(F) dental services;

(G) vision services;

(H) Allied health services;

(I) therapeutic radiologic services;

(J) public health services (including, for the social and other nonmedical needs which affect health status, counseling, referral for assistance, and followup services);

(K) ambulatory surgical services; [and]

(L) health education services (including nutrition education); *and*

(M) other services appropriate to meet the health needs of the service area population.

(b)(1) The Secretary shall assign to high impact areas and any other areas (where appropriate) priorities for the provision of assistance under this section to projects and programs in such areas. The highest priorities for such assistance shall be assigned to areas where the Secretary determines the greatest need exists.

(2) No application for a grant under subsection (c) or (d) for a project in an area which has no migratory agricultural workers may be approved unless grants have been provided for all approved applications under such subsections for projects in areas with migratory agricultural workers.

(c)(1)(A) The Secretary may, in accordance with the priorities assigned under subsection (b)(1), make grants to public and nonprofit private entities for projects to plan and develop migrant health centers which will serve migratory agricultural workers, seasonal agricultural workers, and the members of the families of such migratory and seasonal workers, in high impact areas. A project for which a grant may be made under this subparagraph may include the cost of the [acquisition and modernization of existing buildings] *acquisition, expansion, and modernization of existing buildings, and construction of new facilities* (including the costs of amortizing the principal of, and paying the interest on loans) and the costs of providing training related to the management of migrant health center programs, and shall include—

* * * * * * *

(d)(1) * * *

(2) The costs for which a grant may be made under paragraph (1)(A) may include the costs of [acquiring and modernizing existing buildings] *acquiring, expanding, and modernizing existing buildings, and construction of new facilities* (including the costs of amortizing the principal of, and paying the interest on, loans); and the costs of repaying loans made by the Farmers Home Administration for buildings; and the costs for which a grant or contract may be made under paragraph (1) may include the costs of providing training related to the provision of primary health services, supplemental health services, and environmental health services, and to the management of migrant health center programs.

(3) Not more than two grants may be made under paragraph (1)(C) for the same entity.

[(4)(A) The amount of any grant made in any fiscal year under subparagraph (A) of paragraph (1) to a health center shall be determined by the Secretary, but may not exceed the amount by which the costs of operation of the center in such fiscal year exceed the total of—

[(i) the State, local, and other funds, and

[(ii) the fees, premiums, and third party reimbursements,

which the center may reasonably be expected to receive for its operations in such fiscal year. In determining the amount of such a grant for a center, if the application for the grant requests funds for a service described in subparagraph (D) or (E) of subsection (a)(1) (other than to the extent the funds would be used for the improvement of private property) or a supplemental health service, described in subparagraph (B), (F), (J), or (L) of subsection (a)(7), the Secretary shall include, in an amount determined by the Secretary and to the extent funds are available under appropriation Acts, funds for such service unless the Secretary makes a written finding that such service is not needed and provides the applicant with a copy of such finding.]

(4)(A) The amount of any grant made in any fiscal year under subparagraph (A) of paragraph (1) to a health center shall be determined by the Secretary, but may not exceed the amount by which the costs of operation of the center in such fiscal year exceed the total of the fees, premiums, and third party reimbursements (as well as State, local, and other operational funding), which the center may reasonably be expected to receive for its operations in such fiscal year. In determining the amount of such a grant for a center, if the application for the grant request funds for a service described in subparagraph (D) or (E) of subsection (a)(1) (other than to the extent the funds would be used for the improvement of private property) or a supplemental health service described in subsection (a)(7), the Secretary shall include, in an amount determined by the Secretary and to the extent funds are available under appropriation Acts, funds for such service unless the Secretary makes a written finding that such service is not needed and provides the applicant with a copy of such finding; and

(B) Payments under grants under subparagraph (A) or paragraph (1) shall be made in advance or by way of reimbursement and in such installments as the Secretary finds necessary and adjustments may be made for overpayments or underpayments, except that if in any fiscal year the sum of—

(i) the total of the amounts described in clauses [(i) and (ii)] of subparagraph (A) of this paragraph received by a center in such fiscal year, and

(ii) the amount of the grant to the center in such fiscal year,

exceeded the costs of the center's operation in such fiscal year because the amount received by the center from fees, premiums, and third-party reimbursements was greater than expected, an adjustment in the amount of the grant to the center in the succeeding fiscal year shall be made in such a manner that the center [may retain such an amount (equal to not less than one-half of the amount by which such sum exceeded such costs) as the center can demonstrate to the satisfaction of the Secretary will be used to enable the center] *shall be entitled to retain the additional amount of fees, premiums, and other third party reimbursements as the center will use* (I) to expand and improve its services, (II) to increase the number of persons (eligible under subsection (a) to receive services from such a center) it is able to serve, (III) to construct and modernize its facilities, (IV) to improve the administra-

tion of its service programs, and (V) to establish the financial reserve required for the furnishing of services on a prepaid basis. Without the approval of the Secretary, not more than one-half of such retained sum may be used for construction and modernization of its facilities.

* * * * * * *

(f) (1)–(2) * * *

(3) The Secretary may not approve an application for a grant under subsection (d)(1)(A) unless the Secretary determines that the entity for which the application is submitted is a migrant health center (within the meaning of subsection (a)(1)) and that—

(A) the primary health services of the center will be available and accessible in the center's catchment area promptly, as appropriate, and in a manner which assures continuity;

(B) the center will have organizational arrangements, established in accordance with regulations of the Secretary, for (i) an ongoing quality assurance program (including utilization and peer review systems) respecting the center's services, and (ii) maintaining the confidentiality of patient records;

(C) the center will demonstrate its financial responsibility by the use of such accounting procedures and other requirements as may be prescribed by the Secretary;

(D) the center (i) has or will have a contractual or other arrangement with the agency of the State, in which it provides services, which administers or supervises the administration of a State plan approved under title XIX of the Social Security Act for the payment of all or a part of the center's costs in providing health services to persons who are eligible for medical assistance under such a State plan, or (ii) has made or will make every reasonable effort to enter into such arrangement;

(E) the center has made or will make and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled to insurance benefits under title XVIII of the Social Security Act, to medical assistance under a State plan approved under title XIX of such Act, or to assistance for medical expenses under any other public assistance program or private health insurance program;

(F) the center (i) has prepared a schedule of fees or payments for the provision of its services *which is consistent with locally prevailing rates or charges and which is* designed to cover its reasonable costs of operation and a corresponding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the patient's ability to pay, (ii) has made and will continue to make every reasonable effort (I) to secure from patients payment for services in accordance with such schedules, and (II) to collect reimbursement for health services to persons described in subparagraph (E) on the basis of the full amount of fees and payments for such services without application of any discount,

and (iii) has submitted to the Secretary such reports as he may require to determine compliance with this subparagraph;

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[(h)(1) For the purposes of subsections (c), (d), and (e), there are authorized to be appropriated $43,000,000 for the fiscal year ending September 30, 1982, $47,500,000 for the fiscal year ending September 30, 1983, $51,000,000 for the fiscal year ending September 30, 1984, $45,400,000 for fiscal year 1987 and $45,400,000 for fiscal year 1988. The Secretary may not obligate for grants and contracts under subsection (c)(1) in any fiscal year an amount which exceeds 2 per centum of the funds appropriated under this paragraph for that fiscal year, the Secretary may not obligate for grants under subsection (d)(1)(C) in any fiscal year an amount which exceeds 5 per centum of such funds, and the Secretary may not obligate for contracts under subsection (e) in any fiscal year an amount which exceeds 10 per centum of such funds.]

(h)(1) For the purposes of subsections (c), (d), and (e), there are authorized to be appropriated $52,400,000 for fiscal year 1989, and such sums as are necessary in each of the fiscal years 1990 and 1991. The Secretary may not obligate for grants and contracts under subsection (c)(1) in any fiscal year an amount which exceeds 2 per centum of the funds appropriated under this paragraph for that fiscal year, the Secretary may not obligate for grants under subsection (d)(1)(C) in any fiscal year an amount which exceeds 5 per centum of such funds, and the Secretary may not obligate for contracts under subsection (e) in any fiscal year an amount which exceeds 10 per centum of such funds.

(2) The Secretary may not expend in any fiscal year, for grants under this section to public centers (as defined in the second sentence of subsection (f)(3)) the governing boards of which (as described in subsection (f)(3)(G)(ii)) do not establish general policies for such centers, an amount which exceeds 5 per centum of the funds appropriated under this section for that fiscal year.

(3)(A) In any case in which the amounts appropriated under paragraph (1) exceed $47,400,000 for fiscal year 1989, $51,400,000 for fiscal year 1990, or $55,000,000 for fiscal year 1991, the Secretary shall make the total amount of such excess available for grants to migrant health centers for—

(i) the provision of services for the reduction of the incidence of infant mortality; and

(ii) the development and coordination of referral arrangements between migrant health centers and entities for the health management of infants and pregnant women.

(B) In making grants described in subparagraph (A) from amounts made available pursuant to such subparagraph, the Secretary shall give priority to migrant health centers providing services in any catchment area in which there is a substantial incidence of infant mortality or in which there is a significant increase in the incidence of infant mortality.

(4) The Secretary shall prescribe procedures to assure that—

(A) Grants under subsection (d) of this section to a program or project shall not be terminated in whole or in part unless there

is cause and the program or project has first been afforded reasonable notice and opportunity for a hearing on the record.

(B) No application for a grant under subsection (d) of this section from a program or project that received such a grant in the prior year shall be denied in whole or in part unless there is cause and the program or project has first been afforded reasonable notice and opportunity for a hearing on the record before the Administrator of the Health Resources and Services Administration.

COMMUNITY HEALTH CENTERS

SEC. 330. (a) For purposes of this section, the term "community health center" means an entity which either through its staff and supporting resources or through contacts or cooperative arrangements with other public or private entities provides—

(1) primary health services,

(2) as may be appropriate for particular centers, supplemental health services necessary for the adequate support of primary health services,

(3) referral to providers of supplemental health services and payment, as appropriate and feasible, for their provision of such services,

(4) environmental health services, including, as may be appropriate for particular centers (as determined by the centers), the detection and alleviation of unhealthful conditions associated with water supply, sewage treatment, solid waste disposal, rodent and parasitic infestation, field sanitation, housing, and other environmental factors related to health, [and]

(5) information on the availability and proper use of health services,

(6) patient case management services (including outreach, counseling, referral, and follow-up),

for all residents of the area it serves (referred to in this section as a "catchment area").

(b) For purposes of this section:

(1) The term "primary health services" means—

(A) services of physicians and, where feasible, services of physicians' assistants and nurse clinicians;

(B) diagnostic laboratory and radiologic services;

(C) preventive health services (including children's eye and ear examinations to determine the need for vision and hearing correction, perinatal services, well child services, and family planning services);

(D) emergency medical services;

(E) transportation services as required for adequate patient care;

(F) preventive dental services; and

(G) pharmaceutical services, as may be appropriate for particular centers.

(2) The term "supplemental health services" means services which are not included as primary health services and which are—

(A) hospital services;

(B) home health services;

(C) extended care facility services;

(D) rehabilitative services (including physical therapy) and long-term physical medicine;

(E) mental health services;

(F) dental services;

(G) vision services;

(H) allied health services;

(I) therapeutic radiologic services;

(J) public health services (including, for the social and other nonmedical needs which affect health status, counseling, referral for assistance, and followup services);

(K) ambulatory surgical services;

(L) health education services (including nutrition education); [and]

(M) services which promote and facilitate optimal use of primary health services and the services referred to in the preceding subparagraphs of this paragraph, including, if a substantial number of the individuals in the population served by a community health center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals[.]; *and*

(N) other services appropriate to meet the health needs of the service area population.

(3) The term "medically underserved population" means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services.

(4) In carrying out paragraph (3), the Secretary shall by regulation prescribe criteria for determining the specific shortages of personal health services of an area or population group. Such critiera shall—

(A) take into account comments received by the Secretary from the chief executive officer of a State and local officials in a State; and

(B) include infant mortality in an area or population group, other factors indicative of the health status of a population group or residents of an area, the ability of the residents of an area or of a population group to pay for health services and their accessibility to them, and the availability of health professionals to residents of an area or to a population group.

(5) The Secretary may not designate a medically underserved population in a State or terminate the designation of such a population unless, prior to such designation or termination, the Secretary provides reasonable notice and opportunity for comment and consults with—

(A) the chief executive officer of such State;

(B) local officials in such State; and

(C) the State organization, if any, which represents a majority of community helth centers in such State.

(6) The Secretary may designate a medically underserved population that does not meet the criteria established under paragraph (4) if the chief executive officer of the State in which such population is located and local officials of such Statae recommended the desig-

nation of such population based on unusual local conditions which are a barrier to access to or the availability of personal health services.

(7) The Secretary may not change the criteria established under paragraph (4) without affording public notice and an opportunity for comment on any such proposed changes in accordance with section 553 of title 5, United States Code.

(c)(1) The Secretary may make grants to public and nonprofit private entities for projects to plan and develop community health centers which will serve medically underserved populations. A project for which a grant may be made under this subsection may include the cost of the [acquisition and modernization of existing buildings] *acquisition, expansion, and modernization of existing buildings, and construction of new facilities* (including the costs of amortizing the principal of, and paying the interest on, loans) and shall include—

(A) an assessment of the need that the population proposed to be served by the community health center for which the project is undertaken has for primary health services, supplemental health services, and environmental health services;

(B) the design of a community health center program for such population based on such assessment;

(C) efforts to secure, within the proposed catchment area of such center, financial and professional assistance and support for the project; and

(D) initiation and encouragement of continuing community involvement in the development and operation of the project.

(2) Not more than two grants may be made under this subsection for the same project.

(3) The amount of any grant made under this subsection for any project shall be determined by the Secretary.

(d)(1)(A) The Secretary may make grants for the costs of operation of public and nonprofit private community health centers which serve medically underserved populations.

(B) The Secretary may make grants for the costs of the operation of public and nonprofit private entities which provide health services to medically underserved populations but with respect to which he is unable to make each of the determinations required by subsection (e)(3).

(C) The Secretary may make grants to community health centers to enable the centers to plan and develop the provision of health services on a prepaid basis to some or to all of the individuals which the centers serve. Such a grant may only be made for such a center if—

(i) the center has received grants under subparagraph (A) of this paragraph for at least two consecutive years preceding the year of the grant under this subparagraph;

(ii) the government board of the center (described in subsection (e)(3)(G)) requests, in a manner prescribed by the Secretary, that the center provide health services on a perpaid basis to some or to all of the population which the center serves; and

(iii) the center provides assurances satisfactory to the Secretary that the provision of such services on a prepaid basis will not result in the diminution of health services provided by the

center to the population the center served prior to the grant under this subparagraph.

Any such grant may include the acquisition and modernization of existing buildings and providing training related to management on the provision of health services on a prepaid basis.

(2) The costs of which a grant may be made under paragraph (1)(A) or (1)(B) may include the costs of [acquiring and modernizing existing buildings] *acquiring, expanding, and modernizing existing buildings, and construction of new facilities* (including the costs of amortizing the principal of, and paying interest on, loans), the costs of repaying loans made by the Farmers Home Administration for buildings, and the costs of providing training related to the provision of primary health services, supplemental health services and environmental health services, and to the management of community health center programs.

(3) Not more than two grants may be made under paragraph (1)(B) or (1)(C) for the same entity.

[(4)(A) The amount of any grant made in any fiscal year under paragraph (1) (other than subparagraph (C)) to a community health center shall be determined by the Secretary, but may not exceed the amount by which the costs of operation of the center in such fiscal year exceed the total of—

[(i) the State, local, and other funds, and

[(ii) the fees, premiums, and third-party reimbursements, which the center may reasonably be expected to receive for its operations in such fiscal year. In determining the amount of such a grant for a center, if the application for the grant requests funds for a service described in subsection (a)(4) (other than to the extent the funds would be used for the improvement of private property) or a supplemental health service described in subparagraph (B), (F), (L), or (M) of subsection (b)(2), the Secretary shall include, in an amount determined by the Secretary and to the extent funds are available under appropriation Acts, funds for such service unless the Secretary makes a written finding that such service is not needed and provides the applicant with a copy of such finding.]

(4)(A) The amount of any grant made in any fiscal year under paragraph (1) (other than subparagraph (C)) to a community health center shall be determined by the Secretary, but may not exceed the amount by which the costs of operation of the center in such fiscal year exceed the total of the fees, premiums, and third party reimbursements (as well as State, local, and other operational funding), which the center may reasonably be expected to receive for its operations in such fiscal year. In determining the amount of such grant for a center, if the applicant for the grant requests funds for a service described in subsection (a)(4) (other than to the extent the funds would be used for the improvement of private property) or a supplemental health service described in subsection (b)(2), the Secretary shall include, in an amount determined by the Secretary and to the extent funds are available under appropriation Acts funds for such service unless the Secretary makes a written finding that such service is not needed and provides the applicant with a copy of such finding; and

(B) Payments under grants under subparagraph (A) or (B) of paragraph (1) shall be made in advance or by way of reimbursement and in such installments as the Secretary finds necessary and adjustments may be made for overpayments or underpayments, except that if in any fiscal year the sum of—

(i) the total of the amounts described in clauses [(i) and (ii)] of subparagraph (A) received by a center in such fiscal year, and

(ii) the amount of the grant to the center in such fiscal year, exceeded the costs of the center's operation in such fiscal year because the amount received by the center from fees, premiums, and third-party reimbursements was greater than expected, an adjustment in the amount of the grant to the center in the succeeding fiscal year shall be made in such a manner that the center [may retain such an amount (equal to not less than one-half of the amount by which such sum exceeded such costs) as the center can demonstrate to the satisfaction of the Secretary will be used to enable the center] *shall be entitled to retain the additional amount of fees, premiums, and third party reimbursements as the center will use* (I) to expand and improve its services, (II) to increase the number of persons (eligible to receive services from such a center) it is able to serve, (III) to construct and modernize its facilities, (IV) to improve the administration of its service programs, and (V) to establish the financial reserve required for the furnishing of services on a prepaid basis. Without the approval of the Secretary, not more than one-half of such retained sum may be used for construction and modernization of its facilities.

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(d)(1), the Secretary may require as a condition to the approval of such application assurance that the applicant will provide any specified health services described in subsection (a) or (b) which the Secretary finds is needed to meet specific health needs of the area to be served by the applicant. Such a finding shall be made in writing and a copy shall be provided by the applicant.

(3) Except as provided in subsection (d)(1)(B), the Secretary may not approve an application for a grant under paragraph (1)(A) or (1)(B) of subsection (d) unless the Secretary determines that the entity for which the application is submitted is a community health center (within the meaning of subsection (a)) and that—

(A) the primary health services of the center will be available and accessible in the center's catchment area promptly, as appropriate, and in a manner which assures continuity;

(B) the center will have organizational arrangements, established in accordance with regulations prescribed by the Secretary, or (i) an ongoing quality assurance progam (including utilization and peer review systems) respecting the center's services, and (ii) maintaining the confidentiality of patient records;

(C) the center will demonstrate its financial responsibility by the use of such accounting procedures and other requirements as may be prescribed by the Secretary;

(D) the center (i) has or will have a contractual or other arrangement with the agency of the State, in which it provides services, which administers or supervises the administration of

a State plan approved under title XIX of the Social Security Act for the payment of all or a part of the center's costs in providing health services to persons who are eligible for medical assistance under such a State plan, or (ii) has made or will make every reasonable effort to enter into such an arrangement;

(E) the center has made or will make and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled to insurance benefits under title XVIII of the Social Security Act, to medical assistance under a State plan approved under title XIX of such Act, or to assistance for medical expenses under any other public assistance program or private health insurance program;

(F) the center (i) has prepared a schedule for fees or payments for the provision of its services *which is consistent with locally prevailing rates or charges and which is* designed to cover its reasonable costs of operation and a corresponding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the patient's ability to pay, (ii) has made and will continue to make every reasonable effort (I) to secure from patients payment for services in accordance with such schedules, and (II) to collect reimbursement for health services to persons described in subparagraph (E) on the basis of the full amount of fees and payments for such services without application of any discount, and (iii) has submitted to the Secretary such reports as he may require to determine compliance with this subparagraph;

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(f)(1) The Secretary may provide (either through the Department of Health, Education, and Welfare or by grant or contract) all necessary technical and other nonfinancial assistance (including fiscal and program management assistance and training in such management) to any public or private nonprofit entity to assist it in developing plans for, and in operating as, a community health center, and in meeting requirements of subsection (e)(2).

(2) The Secretary shall make available to each grant recipient undjer this section a list of available Federal and non-Federal resources to improve the environmental and nutritional status of individuals in the recipient's catchment area.

[(g)(1) There are authorized to be appropriated for payments pursuant to grants under this section $400,000,000 for fiscal year 1987 and $400,000,000 for fiscal year 1988.]

(g)(1) There are authorized to be appropriated for payments pursuant to grants under this section $500,000,000 for fiscal year 1989, and such sums as may be necessary in each of the fiscal years 1990 and 1991.

(2) The Secretary may not in any fiscal year—

(A) expend for grants to serve medically underserved populations designated under subsection (b)(6) an amount which exceeds 5 percent of the funds appropriated under this section for that fiscal year; and

(B) expend for grants under subsection (d)(1)(C) an amount which exceeds 5 percent of the funds appropriated under this section for that fiscal year.

(3) The Secretary may not expend in any fiscal year, for grants under this section to public centers (as defined in the second sentence of subsection (e)(3)) the governing boards of which (as described in subsection (e)(3)(G)(ii)) do not establish general policies for such centers, an amount which exceeds 5 per centum of the funds appropriated under this section for that fiscal year.

(4)(A) In any case in which the amounts appropriated under paragraph (1) exceed $435,000,000 for fiscal year 1989, $465,000,000 for fiscal year 1990, or $495,000,000 for fiscal year 1990, the Secretary shall make the total amount of such excess available for grants to community health ceters for—

(i) the provision of services for the reduction of the incidence of infant mortality; and

(ii) the development and coordination of referral arrangements between community health centejrs and entities for the medical management of infants and pregnant women.

(B) In making grants described in supbparagraph (A) from amounts made available pursuant to such subparagraph, the Secretary shall give priority to community health centers providing services to any medically underserved population among which there is a substantial incidence of infant mortality or among which there is a significant increase in the incidence of infant mortality.

(5) The Secretary shall prescribe procedures to assure that—

(A) Grants under subsection (d) of this section to a center or project shall not be terminated in whole or in part unless there is cause and the center or project has first been afforded reasonable notice and opportunity for a hearing on the record; and

(B) No application for a grant under subsection (d) of this section from a center or project that received such a grant in the prior year shall be denied in whole or in part unless there is cause and the center or project has first been afforded reasonable notice and opportunity for a hearing on the record before the Administrator of the Health Resources and Services Administration.

(h) In carrying out this section, the Secretary may enter into a memorandum of agreement with a State. Such memorandum may include, where appropriate, provisions permitting such State to—

(1) analyze the need for primary health services for medically underserved populations within such State;

(2) assist in the planning and development of new community health centers;

(3) review and comment upon annual program plans and budgets of community health centers, including comments upon allocations of health care resources in the State;

(4) assist community health centers in the development of clinical practices and fiscal and administrative systems through a technical assistance plan which is responsive to the requests of community health ceters; and

(5) share information and data relevant to the operation of new and existing community health centers.

(i)(1) Each entity which receives a grant under subsection (d) shall provide for an independent annual financial audit of any books, accounts, financial reports, files, and other paoers and property which relate to the disposition or use of the funds received under such grant and such other funds received by or allocated to the project for which such grant was made. For purposes of assuring accurate, current, and complete disclosure of the disposition or use of the funds received, each such audit shall be conducted in accordance with generally accepted accounting principles. Each audit shall evaluate—

(A) the entity's implementation of the guidelines established by the Secretary respecting cost accounting,

(B) the processes used by the entity to meet the financial and program reporting requirements of the Secretary, and

(C) the billing and collection procedures of the entity and the relation of the procedures to its fee schedule and schedule of discounts and to the availability of health insurance and public programs to pay for the health services it provides.

A report of each such audit shall be filed with the Secretary at such time and in such manner as the Secretary may require.

(2) Each entity which receives a grant under subsection (d) shall establish and maintain such records as the Secretary shall by regulation require to facilitate the audit required by paragraph (1). The Secretary may specify by regulation the form and manner in which such records shall be established and maintained.

(3) Each entity which is required to establish and maintain records or to provide for and audit under this subsection shall make such books, documents, papers, and records available to the Secretary or the Comptroller General of the United States, or any of their duly authorized representatives, for examination, copying or mechanical reproduction on or off the premises of such entity upon a reasonable request therefor. The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have the authority to conduct such examination, copying, and reproduction.

(4) The Secretary may, under appropriate circumstances, waive the application of all or part of the requirements of this subsection to a community health center.

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(j) In making grants under this section, the Secretary shall give special consideration to hte unique needs of frontier areas.

SEC. 330A. ADMINISTRATION OF PROGRAM.

The Secretary may delegate the authority to administer the programs authorized under section 329 and section 330 to any office within the Public Health Service, except that the authority to enter into, modify, or issue approval with respect to grants or contracts, may be delegated only within the central office of the Health Resources and Services Administration.

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